October 5, 2018

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

Re: Application for Kadlec Regional Medical Center, 67 Acute Care Beds

Dear Ms. Sigman:

Enclosed please find two copies of the certificate of need application to add 67 acute care beds to Kadlec Regional Medical Center ("Kadlec") in Benton County. Upon project completion, Kadlec would be licensed for 298 acute care medical/surgical beds, and 337 total beds.

As required, the review and processing fee of $40,470 also is enclosed.

Please contact me if you have any questions regarding this application. Thanks for your assistance.

Sincerely,

Robert Watilo, Chief Strategy Officer
Kadlec Regional Medical Center
888 Swift Road
Richland, WA 99352

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

APPLICATION FOR CERTIFICATE OF NEED
Hospital Projects

(Excluding Sale, Purchase or Lease of Hospital, Nursing Home Related Projects, and CCRC Related Projects)

Certificate of Need applications must be submitted with a fee in accordance with Washington Administrative Code (WAC) 246-310-990 and the instructions on page 2 of this form.

Application is made for a Certificate of Need in accordance with provisions of Chapter 70.38 Revised Code of Washington (RCW) and Rules and Regulations adopted by the Department (WAC 246-310). I hereby certify that the statements made in this application are correct to the best of my knowledge and belief.

APPLICANT(S)

(PLEASE PRINT OR TYPE)

OWNER:

Name and Title of Responsible Officer:
Rob Watilo, Chief Strategy Officer

Legal Name of Owner:
Kadlec Regional Medical Center

Address of Owner:
888 Swift Road
Richland, WA 99352

Signature of Responsible Officer:
Robert a Watilo

Date: 10/5/18 Telephone: (509) 897-2018

(PLEASE PRINT OR TYPE)

OPERATOR:

Name and Title of Responsible Officer:
Rob Watilo, Chief Strategy Officer

Legal Name of Operator:
Kadlec Regional Medical Center

Address of Operator:
888 Swift Road
Richland, WA 99352

Signature of Responsible Officer:
Robert a Watilo

Date: 10/5/18 Telephone: (509) 897-2018

TYPE OF OWNERSHIP:

- ☐ District
- ☒ Private Non-Profit
- ☐ Proprietary – Corporation
- ☐ Proprietary – Individual
- ☐ Proprietary – Partnership
- ☐ State or County

Proprietor(s) or Stockholder(s) information:
Provide the name and address of each owner and indicate percentage of ownership:

OPERATION OF FACILITY:

- ☒ Owner Operated
- ☐ Management Contract
- ☐ Lease

TYPE OF PROJECT (*check all that apply*):

- ☐ New Health Care Facility
- ☒ Bed Addition
- ☐ New Tertiary Health Service
- ☐ Pre-Development Expenditure
- ☐ Other

Intended Project Start Date:

March 2019 or upon CN Approval

ESTIMATED CAPITAL EXPENDITURE:

$1,416,100

Project Description: Kadlec Regional Medical Center proposes to add 67 beds to the existing medical center.

INSTRUCTIONS FOR SUBMISSION: DO NOT bind your application. Bindings, notebooks and other covers are not necessary. Please number the pages at the bottom, and two-hole punch the application material at the top of the pages.

1. Mail two copies of the completed application, with narrative portion to:

Department of Health
Certificate of Need Program
PO Box 47852
Olympia, Washington 98504-7852

The application must be accompanied by a check, payable to: ***Department of Health***.

2. COMPLETE THE FOLLOWING PRIOR TO SUBMISSION FOR REVIEW:

TOTAL AMOUNT OF FEE ACCOMPANYING THIS APPLICATION:

REVIEW FEE: $40,470

APPLICANT NAME: Kadlec Regional Medical Center

DATE OF SUBMISSION: October 5, 2018 CHECK NUMBER:[1] 97929

[1] Please see Exhibit 1 for a copy of the check to the Department of Health.

APPLICATION INFORMATION INSTRUCTIONS

These application information requirements are to be used in preparing a Certificate of Need application.

The information will be used to evaluate the conformance of the project with all applicable review criteria contained in RCW 78.38.115 and WAC 248-19-328, 370, 380, 390, and 400, and standards contained in the Washington State Health Plan.

1. The application is to be submitted together with a completed and signed Certificate of Need application face sheet and the appropriate review and processing fee. Two copies are to be sent to: **Certificate of Need Program**.

2. Submit a copy of the **Letter of Intent**[2] for this project in the application.

3. Please make the narrative information complete and concise. Data sources are to be cited. Extensive supporting data which would tend to interrupt the narrative should be placed in the Exhibit. Please number **ALL** pages.

4. All cost projections are to be in noninflated dollars. Use the current year dollar value for all proforma data and projections. **Do not** inflate these dollar amounts.

5. Capital expenditures should not include contingencies. Certificate of Need statute and regulations allow a 12% or $50,000, whichever is greater, margin before an amendment to an approved Certificate is required.

[2] Please see Exhibit 2 for a copy of the Letter of Intent.

Kadlec Regional Medical Center

Certificate of Need Application

Proposing to Add 67 Acute Care Beds

October 2018

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Introduction and Summary

Kadlec Regional Medical Center ("Kadlec") requests Certificate of Need ("CN") approval for 67 new acute care beds in the Benton-Franklin Planning Area ("Planning Area"). Kadlec is a tertiary referral center that has been serving the needs of the residents of Benton and Franklin Counties and other regional patients since 1944. Throughout its history, Kadlec has continued to plan for and anticipate the future health care needs of Benton and Franklin Counties and the surrounding region. Kadlec offers comprehensive medical and surgical services, specializing in cancer, heart, neurological, and orthopedic care. The hospital is designated within Washington's Emergency Medical Services and trauma system as a Level III adult trauma provider.

Kadlec is currently licensed to operate 270 beds. Through the Certificate of Need process, Kadlec is seeking to add 67 beds to its licensed capacity for a total of 337 beds. The proposed expansion will occur in three phases, adding bed capacity during a 3-year period to meet growing need. The first phase will occur immediately following issuance of the CN and will add 10 beds in 2019. This will be followed by adding 20 beds in 2020 and the remaining 37 beds in 2021. This phased approach allows Kadlec to immediately add beds to meet current need and then to add beds in the following years as the Planning Area's need for additional beds increases.

Due to the need for additional acute care medical/surgical beds in the Planning Area, together with high bed occupancy rates at Kadlec, the hospital faces challenges in its ability to provide care for the growing community. The proposed bed expansion responds to current utilization trends and addresses the future need for acute care bed capacity in the Planning Area to serve the residents' increasing health care needs.

Bed Need

In order to determine whether there is need for new hospital beds, the Department relies upon the Bed Need Forecasting Method contained in the 1987 State Health Plan. Utilizing the Forecasting Method, the numeric need for additional beds is calculated for the planning area in which a hospital is located using a seven-year "planning horizon," with the seventh year following the most recent year for which patient day statistics are available being the "target year" for the purpose of calculating bed need. In this case, the target year is 2024. Kadlec is located in the Benton-Franklin Planning Area.

According to the Forecasting Method, in 2018, there is an estimated net need for 10 acute care beds in the Planning Area. The need for acute care beds continues to grow rapidly in the years that follow by an average of 10-11 beds per year, increasing to a need for 77 beds in 2024, which, as noted above, is the target year for the seven-year planning horizon. Accordingly, under the bed need Forecasting Method, there is significant net need for the 67 new beds proposed by Kadlec.

Planning Area Growth

The Planning Area population has demonstrated steady population growth from 2010-2015, averaging 1.7% per year. Population growth is forecasted to continue growing

steadily through 2030. Significantly, the number of persons in the 65+ age cohort grew 5.0% annually from 2010 to 2015 and is forecasted to grow 4.2% annually from 2015 to 2020, 3.7% annually from 2020-2025, and 2.8% annually from 2025 to 2030. This is important, as older residents are much more frequent users of health care services.

Based on the forecast model for the Benton-Franklin Planning Area, at 1,035 patient days per 1,000 residents, the 65+ age group has a hospitalization use rate that is more than five times that of residents younger than the age of 65. In addition, since Kadlec increased to a Level III adult trauma center, patients from outside the Planning Area have increasingly relied on Kadlec for inpatient care. There has been steady growth of in-migration of patient days to Kadlec during the past five years at 5.1% per year.

Emergency Department: Inpatient Admissions

Kadlec is the largest trauma center in the Planning Area. As a Level III adult trauma center, it is vital that Kadlec continues to meet the demand for inpatient care. For the past three years, the Kadlec emergency department has seen solid growth, with the number of visits reaching 98,257 in 2015, 95,729 in 2016, and 100,620 in 2017. In 2017, 62% of Kadlec's inpatient admissions came from the emergency department. Therefore, as the emergency department volumes increase, so do inpatient admissions.

Occupancy and Growth in Patient Days

Kadlec's acute care bed occupancy rate has been increasing steadily and averaged a 73.6% occupancy in 2017. Without the project, Kadlec's occupancy is projected to reach 77.2% by 2019 and 83.6% by 2023. This rate is in excess of the Department's hospital occupancy standard of 70% that is used when calculating the need for acute care beds.

The average annual growth rate of Kadlec's inpatient days from 2013-2017 was 3.8% overall and 5.0% when excluding neonates, psychiatric services, and rehabilitation services. Without the project, beginning in 2018, the annual projected growth in Kadlec's patient days averages 2% annually each year thereafter until a maximum occupancy is met. This reduction in patient day growth reflects growing occupancy constraints over time, without the project.

As one of four hospitals in the Planning Area (two of which are critical access hospitals, and are thus limited to 25 acute care beds), Kadlec must adequately plan to meet the current and future need for acute care hospital beds. Without this proposed bed expansion, as occupancy rises residents of the Planning Area will be compelled to seek care outside the community, particularly during times of seasonal occupancy peaks. Further, without the project, Kadlec's ability to serve as the trauma safety net eventually could be compromised, particularly if a catastrophic event occurs that requires the immediate availability of many inpatient beds. Approval of this Certificate of Need application will enable Kadlec to ensure acute care services will be available to meet current and future community need.

I. APPLICANT DESCRIPTION

A. Legal name(s) of applicant(s).

The applicant's legal name is Kadlec Regional Medical Center.

B. Address of each applicant.

Kadlec Regional Medical Center
888 Swift Boulevard
Richland, Washington 99352

C. If an out-of-state corporation, submit proof of registration with Secretary of State, Corporations, Trademarks and Limited Partnerships Division, and a chart showing organizational relationship to any related organizations as defined in Section 405.427 of the Medicare Regulations.

Kadlec Regional Medical Center is a Washington not-for-profit corporation; therefore, the question is not applicable.

D. Provide separate listings of each Washington and out-of-state health care facility, including name, address, Medicare provider number, Medicaid provider number, owned and/or managed by each applicant or by a related party, and indicate whether owned or managed. For each out-of-state facility, provide the name, address, telephone number and contact person for the entity responsible for the licensing/survey of each facility.

Kadlec is a 501(c)(3) corporation, and its sole corporate member is Western HealthConnect, a Washington non-profit corporation. On July 1, 2016, Western HealthConnect and St. Joseph Health System, a California non-profit corporation, become affiliated. The new affiliation creates a new "super-parent", Providence St. Joseph Health, a Washington non-profit corporation, which is the sole corporate member of Western HealthConnect. It is important to note that Western HealthConnect remains a viable corporation, as do the subsidiaries and D/B/As that fall under that corporate umbrella. This new affiliation did not change the name or corporate structure of Western HealthConnect, or Kadlec Regional Medical Center.

For the purposes of this CN application, Providence's legal structure has been provided in Exhibit 3. In addition, an organizational chart for Kadlec is provided in Exhibit 4. Please see Exhibit 5 for a list of the facilities owned, operated, and managed by Providence Health & Services.

Table 1 lists the Medicare and Medicaid provider numbers for Kadlec Regional Medical Center.

Table 1. Kadlec Medicare and Medicaid Provider Numbers

	Medicare Provider Number	Medicaid Provider Number
Acute Care	50-0058	3311305
Inpatient Rehab	50-T058	3200235

Source: Kadlec

E. Facility licensure/accreditation status.

Kadlec is licensed by the Washington State Department of Health and accredited by The Joint Commission. Kadlec also participates in numerous accreditation, licensure and certification reviews by external agencies. Those licensures, accreditations, and certifications are listed below, followed by the year the most recent designation expires:

- Washington State Department of Health, Hospital License, 2019
- The Joint Commission, Hospital Accreditation Program, 2020
- Commission on Accreditation of Rehabilitation Facilities (CARF), 2020
- Level III acute care trauma service designation by the Washington Emergency Medical Services and Trauma System, 2019
- Level II joint rehabilitation trauma service designation by the Washington Emergency Medical Services and Trauma System, 2019
- College of American Pathologists (CAP) lab certification, 2019
- Commission on Cancer Certificate with commendation by the American College of Surgeons, (American College of Surgeons Commission on Cancer Certified), 2018
- American College of Radiology in Mammography, College of Radiology Accredited Facility, Outpatient Imaging Center-Kadlec, 2021
- American College of Radiology, Breast Imaging Services, Mammography-Kadlec Regional Medical Center-OPIC, 2020
- American College of Radiology in Stereotactic Breast Biopsy Imaging Services, 2020
- American College of Radiology, Breast MR Imaging Services, 2021
- Stroke Certification, The Joint Commission, 2020
- Joint Replacement Certification-Shoulder, Hip, Knee, The Joint Commission, 2020
- Quality Oncology Practice Initiative (QOPI) Certification, 2019
- Board of Pharmacy Inspection – Last surveyed January 2018

- FSED Laboratory, Department of Health – Inspection to occur every two years; last inspection date: 10/19/2017; inspection due: October 2019
- Washington State Department of Health Recognition Antimicrobial Stewardship Honor Roll, 2016 and 2017

F. Is applicant reimbursed, or plans to be reimbursed, for services under Titles V, XVIII, and XIX of Social Security Act?

Kadlec is reimbursed under Titles V, XVIII, and XIX of the Social Security Act.

G. Describe the history of each applicant with respect to criminal convictions related to ownership/operation of health care facility, license revocations and other sanctions described in WAC 248-19-390 (5)(a). If there have been no convictions or sanctions, so state.

There have been no such convictions or sanctions as described in WAC 248-19-390(5)(a) (now codified as WAC 246-310-230(5)(a)) for either PH&S-Washington or Kadlec.

II. FACILITY DESCRIPTION

A. Name and address of the proposed/existing facility.

Kadlec Regional Medical Center
888 Swift Boulevard
Richland, Washington 99352

B. Name and address of owning entity at completion of project (unless same as applicant).

Same as applicant.

C. Provide the following information about the owning entity (unless same as applicant).

1. **If an out-of-state corporation, submit proof of registration with Secretary of State, Corporations, Trademarks, and Limited Partnership Division, and a chart showing organizational relationships to any related organizations as defined in Section 405.427 of the Medicare Regulations.**

   The owning entity is the same as the applicant and is not an out-of-state entity.

2. **If an out-of-state partnership, submit proof of registration with Secretary of State, Corporations, Trademarks, and Limited Partnership Division, and a chart showing organizational relationships to any related organizations as defined in Section 405.427 of the Medicare Regulations.**

   The owning entity is the same as the applicant and is not an out-of-state entity.

D. Name and address of operating entity (unless same as applicant).

The operating entity is the same as the applicant.

E. Geographic identity of primary service area.

Consistent with the Department of Health's Certificate of Need acute care bed need methodology, the Benton-Franklin Planning Area ("Planning Area") is used as the geographic unit of analysis. The definition of the Planning Area by city and zip code is provided in Table 2. A map of the Planning Area is provided in Exhibit 6. It should be noted that Kadlec is an acute tertiary referral and trauma center, providing a comprehensive scope

of inpatient and outpatient services as well as specialized tertiary[3] services to a much broader group of residents primarily from Benton and Franklin Counties, but also from surrounding counties in Washington, as well as Oregon.

Table 2. Benton-Franklin Planning Area Definition

County	Zip Code	City
Benton	99320	BENTON CITY
Benton	99336	KENNEWICK
Benton	99337	KENNEWICK
Benton	99338	KENNEWICK
Benton	99345	PATERSON
Benton	99346	PLYMOUTH
Benton	99350	PROSSER
Benton	99352	RICHLAND
Benton	99353	WEST RICHLAND
Benton	99354	RICHLAND
Franklin	99301	PASCO
Franklin	99302	PASCO
Franklin	99326	CONNELL
Franklin	99330	ELTOPIA
Franklin	99335	KAHLOTUS
Franklin	99343	MESA

[3] Washington Administrative Code 246-310-010(58) defines tertiary health service as a "specialized service meeting complicated medical needs of people and requires sufficient patient volume to optimize provider effectiveness, quality of service and improved outcomes of care." WAC 246-310-020(1)(d)(i)(A)-(G) identifies "tertiary services" as specialty burn services, intermediate care nursery and/or obstetric services level II, neonatal intensive care nursery and/or obstetric services level III, transplantation of specific solid organs, open heart surgery and/or elective therapeutic cardiac catheterization, inpatient physical rehabilitation services level I, and specialized inpatient pediatric services.

F. Peer Group.

This question is not applicable.

G. List physician specialties represented on active medical staff and indicate number of active staff per specialty.

As of 2018, the medical staff at Kadlec includes a total of 238 active medical staff members. Please refer to Exhibit 7 for a listing of the number of active medical staff by specialty at Kadlec.

H. List all other generally similar providers currently operating in the primary service area.

There are four hospitals in the Benton-Franklin Planning Area:

1. Kadlec Regional Medical Center, Richland
2. Lourdes Medical Center, Pasco
3. PMH Medical Center, Prosser
4. Trios Health, Kennewick

I. For existing hospitals, provide:

Inpatient days/year for the last five years

The total inpatient days at Kadlec during the period 2013-2017 are presented in Tables 3 and 4.

Table 3. Kadlec Total Inpatient Days (No Exclusions)

	2013	2014	2015	2016	2017	Average Annual Growth, 2013-2017
Patient Days	66,277	65,778	69,401	69,692	77,045	3.84%
Annual Growth		-0.8%	5.5%	0.4%	10.6%	

*All DRGs and MDCs
Source: CHARS 2013-2017

Table 4. Kadlec Total Inpatient Days (Exclusions)

	2013	2014	2015	2016	2017	Average Annual Growth, 2013-2017
Patient Days	51,108	52,392	55,589	55,138	62,045	4.97%
Annual Growth		2.5%	6.1%	-0.8%	12.5%	

*Excludes Neonates (DRGs 789-795), Psych (MDC 19) and Rehab (DRGs 945 and 946), and Rehabilitation Unit Utilization
Source: CHARS 2013-2017

Total licensed bed capacity at present

Kadlec is licensed for 270 beds. Table 5 provides the number of current licensed beds by type.

Table 5. Kadlec Current Licensed Beds by Type

Bed Type	Current
Acute Care	231
Inpatient Rehab	12
NICU Level II & III	27
Total Licensed Bed Capacity	**270**

Source: Kadlec

Average number of set-up beds in last 12 months

Kadlec has had 231 licensed acute care medical/surgical beds set-up in the last 12 months.

J. If this project involves construction of 12,000 square feet or more, or construction associated with parking for forty or more vehicles, submit a copy of either an Environmental Impact Statement or a Declaration of Non-Significance from the appropriate governmental authority.

This question is not applicable. The project does not involve construction of 12,000 square feet or more. The only construction is adding two showers on floor 2 in phase 2. Please see Exhibit 8 for a zoning confirmation letter from the City of Richland, providing details that the property is appropriately zoned for the current and intended use.

III. PROJECT DESCRIPTION

A. Describe the proposed project. This description should include discussion of any proposed conversion or renovation of existing space to other purposes, as well as the construction of new facility space. Also specify any unique services being proposed.

Kadlec is currently licensed to operate 270 total hospital beds. Through the Certificate of Need process, Kadlec is seeking to add 67 acute care beds, for a total of 337 beds.

The proposed expansion will occur in three phases. Phase 1 will occur following issuance of the CN and will add 10 beds in March 2019. Phase 2 will occur in January 2020, adding 20 beds. Phase 3 will occur in January 2021, adding the remaining 37 beds, for a total of 67 new acute beds added during the 2019-2020 period. Taking a phased approach to adding beds allows Kadlec to bring on capacity immediately after CN approval, and then continue to add capacity as need increases in the following years. In addition, the phased approach minimizes disruption to existing operations at Kadlec.

The project will involve minimal construction: the only construction will be adding two shower stalls in late 2019 to coincide with the addition of 20 beds in January 2020. Since the project will involve minimal construction, there will be no disruption to patient services at any point during the project.

There will be no changes to the services being offered at Kadlec other than increasing current services as bed capacity is added. Given that the Planning Area is undergoing significant changes, with two of the four hospitals in the Planning Area changing ownership in 2018 and moving from not-for-profit to for-profit entities, Kadlec will continue to monitor the market and adjust services to meet the needs of the community.

B. Type of Project (indicate all that apply):

1. **____ New Facility or Service**
2. **___ Total Replacement of Existing Facility**
3. **___ Renovation or Modernization**
4. **___ Mandatory Correction of Fire and Life/Safety deficiencies**
5. **___ Substantial Change in Services**
6. **_X_ Expansion/Reduction of Facility**
7. **___ Pre-Development Expenditure in Excess of Minimum**

C. If the proposed project involves the purchasing of an existing service, identify the present owners (s) of that service.

The proposed project does not involve purchasing an existing service.

D. Describe any changes in licensed and/or set-up bed capacity by unit/service which are part of this project.

Kadlec is currently licensed for 270 beds. Kadlec proposes to increase its licensed bed capacity by an additional 67 beds. At project completion, Kadlec will be licensed for a total of 337 beds. Current and proposed bed counts, by type of bed, are identified in Table 6.

Table 6. Kadlec Current and Proposed Beds by Type

Bed Type	Current	Proposed
Acute Care	231	298
Inpatient Rehab	12	12
NICU Level II & III	27	27
Total Licensed Bed Capacity	270	337

Source: Kadlec

E. Total estimated capital expenditures.

The capital expenditure for this project is $1,416,100.

F. Total estimated additional facility-wide operating expense for the first and second years of operation (separately shown).

An estimate of the facility-wide operational expenses is included in Table 7 with the project and Table 8 without the project.

Table 7. Kadlec Facility-Wide Operating Expenses - With Project

	Total Operating Expense*
2019	$549,756,497
2020	$580,301,172
2021	$615,209,391
2022	$644,187,984
2023	$674,870,927
2024	$707,965,159

Source: Kadlec

*Does not include system overhead allocation. Please see Exhibit 9, Statement of Revenue and Expenses, for system overhead allocation.

Table 8. Kadlec Facility-Wide Operating Expenses - Without Project

	Total Operating Expense*
2019	$548,490,219
2020	$572,654,490
2021	$598,145,757
2022	$625,481,630
2023	$654,449,084
2024	$681,319,934

*Does not include system overhead allocation. Please see Exhibit 10, Statement of Revenue and Expenses, for system overhead allocation.

Please see Exhibit 9 for the proforma financial statements with the project and Exhibit 10 for the proforma financial statements without the project.

G. General description of types of patients to be served by the project. Describe the extent of any planned limitations to the services offered, either during the initial years of the project or on a permanent basis.

As stated earlier, Kadlec provides inpatient care as well as tertiary level services and has no plans to limit these services during or after the project. Kadlec's licensed beds will continue to be used to provide critical care, medical/surgical care, obstetrics, cardiac care, interventional cardiology, Level II and III neonatal intermediate care, pediatrics, and inpatient rehab.

H. Projected utilization of service(s) for the first three years of operation following project completion (shown separately). This should be expressed in appropriate workload units of measure (for hospitals, appropriate workload units of measure and ACMVUs as required in the Accounting and Reporting Manual for Hospitals of the State Hospital Commission should be used). RVU measures should also be expressed in procedure units.

Table 9 provides the Kadlec acute care patient day forecast during 2018-2022. Year 2022 will be the third full year after the project is completed.

Table 9. Kadlec Acute Care Patient Day Forecasts, 2018-2022

	2018	2019	2020	2021	2022
Total Patient Days*	63,822	66,598	70,263	75,105	77,096

*Excludes Neonates (DRGs 789-795), Psych (MDC 19) and Rehab (DRGs 945 and 946)
*Excludes Rehabilitation Unit utilization

I. If applicable, include a copy of the functional program.

This question is not applicable. The additional beds will be located on existing floors at Kadlec, with minimal construction that is limited to adding two shower stalls, so patient care will have minimal disruption as beds are added to the facility.

J. Existing sources of patient revenue (Medicare, etc.) with Percentage of revenue from each source.

The hospital-wide payer mix at Kadlec is shown in Table 10.

Table 10. Kadlec Payer Mix as a percent of Total Gross Charges (Hospital-Wide): 2017

Source	Percent
Medicare	41.6%
Medicaid	23.0%
Commercial	30.2%
Other Government/L&I	2.8%
Private Self-pay	2.5%
Total	100%

Source: Kadlec, 2017
*Excludes Normal Newborns

.

K. Sources of financing.

This project will be financed solely through Kadlec's cash reserves via Western HealthConnect.

L. Equipment proposed:
1. Description of new and replacement equipment proposed.

A list of the proposed equipment is included in Exhibit 11.

2. Description of equipment to be replaced, including cost of equipment and salvage value, if any, or disposal or use of the equipment to be replaced.

For the proposed project, there will be no equipment that needs to be replaced. Other than the equipment identified in Exhibit 11, totaling $1,253,200 (including sales tax), the equipment is existing and already in place.

M. Single line drawings to scale of current locations which identify current departments and services.

Please refer to Exhibit 12 for drawings of current locations.

N. Single line drawings to scale of proposed locations which identify proposed services and departments.

Please refer to Exhibit 13 for drawings of proposed locations.

O. Geographic location of site of proposed project, if other than hospital campus.

1. Indicate the number of acres in the site:

The Kadlec campus includes approximately 24 acres.

2. Indicate the number of acres in any alternative site, if applicable.

This question is not applicable.

3. Indicate if the primary site or alternate site has been acquired, if applicable.

This question is not applicable. The proposed project will be located in existing buildings on the Kadlec campus.

4. **Address of the site:**

Kadlec Regional Medical Center
888 Swift Boulevard
Richland, Washington 99352

Address of alternative site:

This question is not applicable.

5. **If the primary site or alternate site has not been acquired, explain how you will select and acquire a site for the proposed project.**

   This question is not applicable.

6. **Describe any of the following which would currently restrict usage of the proposed site and/ or alternate site for the proposed project:**

   (a) mortgages; (b) liens; (c) assessments; (d) mineral or mining rights; (e) restrictive clauses in the instrument of conveyance; (f) easements and right of ways; (g) building restrictions; (h) water and sewer access; (i) probability of flooding; (j) special use restrictions; (k) existence of access roads; (l) access to power and/or electricity sources; (m) shoreline management/ environmental impact; (n) others, please explain.

   None of the above will restrict usage of the proposed site.

7. **Provide documentation that the proposed site may be used for the proposed project. Include a letter from any appropriate municipal authority indicating that the site for the proposed project is properly zoned for the anticipated use and scope of the project or a written explanation of why the proposed project is exempt.**

   Please refer to Exhibit 8, which provides the necessary information that the site may be used for the proposed project.

8. **Provide documentation that the applicant has sufficient interest in the site or facility proposed. Sufficient interest shall mean one of the following:**

   a. **Clear title to the proposed site or**

      The proposed site is Kadlec-owned property. Please refer to Exhibit 14 for the Purchase and Sale Agreement.

   b. **A lease for at least five years with options to renew for not less than a total of twenty years in the case of a hospital, psychiatric hospital, tuberculosis hospital, or rehabilitation facilities; or**

      This question is not applicable.

   c. **A lease for at least one year with options to renew for not less than a total of five years in the case of freestanding**

kidney dialysis units, ambulatory surgical facilities, hospices, or home health agencies; or

This question is not applicable.

d. A legally enforceable agreement to give such title or such lease in the event that a Certificate of Need is issued for the proposed project.

This question is not applicable.

P. Space Requirements

1. Existing gross square feet:

Kadlec consists of 633,953 total gross square feet ("GSF"). Table 11 provides a breakdown of the gross square feet by floor.

Table 11. Kadlec Existing Gross Square Feet

Location	Gross Sq. Ft.
Level 0 (crawl space)	47,263
1st floor	182,830
2nd floor	133,342
3rd floor	76,829
4th floor	49,811
5th floor	24,496
6th floor	24,496
7th floor	23,115
8th floor	23,115
9th floor	23,115
10th floor	23,115
11th floor	2,426
Total	**633,953**

Source: Kadlec

2. Total gross square footage for proposed new addition and existing facility or proposed gross square footage for the proposed entirely new facility.

The proposed expansion is located on floors 2, 3, and 4 in the hospital tower. The GSF for the rooms in which the beds will be located include the following: Floor 2 bed addition will consist of 11,400 GSF, Floor 3 bed addition will consist of 9,654 GSF, and Floor 4 bed addition will consist of 5,229 GSF.

3. Provide a matrix showing net square feet for all involved services and departments before and after project completion.

Since the project is being implemented in existing space, there will be no changes to the net square feet for the locations of the proposed beds after the project completion. Please note that the NSF and GSF provided below only represents the room space that will house the beds. It does not include existing support areas. Table 12 provides a breakdown of the net square feet for the floors impacted by this project.

Table 12. Kadlec Net Square Feet for Involved Departments

Facility/Floor	Total Number of Beds at Project Completion	Net Square Feet Before Project	Net Square Feet After Project	Gross Square Feet
Floor 2	20	7,600	7,600	11,400
Floor 3	37	6,336	6,336	9,654
Floor 4	10	3,486	3,486	5,229
Total	**67**	**17,422**	**17,422**	**26,283**

Source: Kadlec

4. Do the above responses include any shelled-in areas? If yes, explain the type of shelled-in space proposed (administration, patient beds, therapy space, etc.)

The proposed project will not include any shelled-in areas. The Kadlec facility in which the new beds will be located is fully built out. Other than the construction of two shower stalls, the project only requires the minimal addition of new equipment in order to be operational.

Q. Proposed Timetables for Project Implementation.

The Certificate of Need Program will use the following timetable in monitoring the applicant's conformance with the issued Certificate of

Need. Failure to meet the specified timetable may be grounds for revocation of a Certificate of Need. (WAC 246-310-500)

1. Financing, if project is to be externally funded:

a. Date for obtaining construction financing.

This question is not applicable.

b. Date for obtaining permanent financing.

This question is not applicable.

c. Date for obtaining funds necessary to undertake the project.

This question is not applicable.

2. Design

a. Date for completion and submittal to Consultation and Construction Review Section of preliminary drawings.

Phase 1: Adding 10 beds to floor 4 does not require CRS review, as there is no construction required.

Phase 2: Adding 20 beds to floor 2 includes adding two shower stalls. To meet CRS requirements, preliminary drawings will be submitted by October 2019.

Phase 3: Adding 37 beds to floor 3 does not require CRS review, as there is no construction required.

b. Date for completion and submittal to Consultation and Construction Review Section of final drawings and specifications.

Phase 1: Adding 10 beds to floor 4 does not require CRS review, as there is no construction required.

Phase 2: Adding 20 beds to floor 2 includes adding two shower stalls. To meet CRS requirements, final drawings will be submitted by November 2019.

Phase 3: Adding 37 beds to floor 3 does not require CRS review, as there is no construction required.

3. Construction

a. Date for construction contract award.

June 2019

b. Date for 25 percent completion of construction (25% of the dollar value of the contract in place).

November 2019

c. Date for 50 percent completion of construction.

November 2019

d. Date for 75 percent completion of construction.

December 2019

e. Date for completion of construction.

December 2019

f. Date for obtaining licensure approval.

Phase 1: Adding 10 beds in March 2019.
Licensure approval will be obtained in March 2019.

Phase 2: Adding 20 beds in January 2020.
Licensure approval will be obtained in January 2020.

Phase 3: Adding 37 beds in January 2021.
Licensure approval will be obtained in January 2021.

g. Date for occupancy / offering of service(s).

Phase 1: Adding 10 beds in March 2019. Occupancy will occur immediately following licensure in March 2019.

Phase 2: Adding 20 beds in January 2020. Occupancy will occur immediately following licensure in January 2020.

Phase 3: Adding 37 beds in January 2021. Occupancy will occur immediately following licensure in January 2021.

R. As the applicant(s) for this project, describe your experience and expertise in the planning, developing, financing and construction of this type of project.

Providence has provided patient care since 1856, with the first hospital opening in 1887. Providence continues a tradition of caring that the Sisters of Providence began more than 160 years ago. As part of Providence and Western HealthConnect, Kadlec has access to extensive expertise in the planning, developing, financing, and construction of this type of project.

Some of Providence's recent Certificate of Need projects include, but are not limited to, the following:

- **2017, Providence Regional Medical Center Everett –** Approval to add 70 acute care beds to its current hospital in Snohomish County
- **2017, Kadlec Regional Medical Center –** Approval to construct and operate a 3-OR ambulatory surgical facility in Benton County
- **2017, Providence Regional Medical Center Everett** – Approval to operate a 5-OR ambulatory surgical facility in Snohomish County
- **2016, Inland Behavioral Health, a joint venture between Providence Health Care and UHS-Fairfax Behavioral Health** – Approval to construct and operate a 100-bed psychiatric hospital in Spokane County
- **2016, Swedish Health Services** – Approval to establish a 3-OR ambulatory surgical facility in Redmond
- **2014, Providence Health Care** – Approval to establish a 4-OR ambulatory surgical facility in Providence Medical Park, Spokane Valley
- **2014, Swedish Health Services** – Approval to establish an ambulatory surgical facility in Issaquah
- **2011, Providence Sacred Heart Medical Center** – Approval to begin performing adult pancreatic transplants
- **2011, Providence Regional Medical Center Everett** – Approval to increase its acute care bed license to 396 beds, to include 23 bassinets
- **2010, Providence Sacred Heart Medical Center** – Approval to increase its acute care bed license by 75 beds

S. Describe the relationship of this project to the applicant(s)' long range plan and long range financial plan (if any).

This Certificate of Need application for additional acute care beds at Kadlec is an essential element of our long range strategic and financial plans for meeting the needs of residents of Benton and Franklin Counties and the surrounding region who are seeking inpatient hospital services.

Kadlec is one of four acute care hospitals in the Benton-Franklin Planning Area. Kadlec has the busiest emergency department in the Planning Area and admits approximately 62% of emergency department patients into its inpatient care setting. As such, the hospital plays an integral role in addressing the health care needs of the residents of the Planning Area and the region as a whole.

It is imperative that Kadlec have the necessary acute care bed capacity to respond to growth in the region. As discussed in Section IV below, there has been steady adult population growth in the Planning Area during the past 10 years, and that growth is expected to continue (Table 16).

With population increases and the aging of the population, Kadlec is experiencing, and will continue to experience, an increasing demand for inpatient services. The proposed bed expansion is in response to current utilization trends and in preparation for the future need for more acute care bed capacity in the Planning Area to serve the residents' increasing health care needs. Further, as noted earlier, Kadlec is a regional tertiary and trauma referral center to a much broader geographic region, including Benton and Franklin counties and the surrounding counties in Washington, as well as Oregon.

IV. PROJECT RATIONALE

A. NEED

1. Identify and analyze the unmet health services needs and/or other problems to which this project is directed.

a. Unmet health services needs of the defined population should be differentiated from physical plant and operating (service delivery) deficiencies which are related to present arrangements.

Kadlec has served the health care needs of the residents of Benton and Franklin Counties and of the surrounding region for 74 years. Throughout its history, Kadlec has continued to plan for and anticipate the future needs of the community it serves.

As discussed below, there is a current and future need for additional acute care beds in the Planning Area and at Kadlec. This need must be addressed if Kadlec is to continue its mission of providing accessible, high-quality care to residents of the Planning Area and the surrounding region. Kadlec's proposed 67-bed expansion responds to current utilization trends and addresses the significant need for new acute care bed capacity in the Planning Area.

Bed Need

In order to determine whether there is a need for new acute care beds, the Department of Health relies upon the Bed Need Forecasting Method contained in the 1987 State Health Plan. Utilizing the Forecasting Method, the numeric need for new beds is calculated for the planning area in which a hospital is located using a seven-year "planning horizon," with the seventh year following the most recent year for which patient day statistics are available being the "target year" for the purpose of calculating bed need. In this case, the target year is 2024. Kadlec is located in the Benton-Franklin Planning Area.

According to the Forecasting Method, there is an estimated shortage of 10 acute care beds in the Planning Area in 2018. The need for acute care beds in the Planning Area continues to grow rapidly in the years that follow by 10 to 11 beds per year, increasing to a need for 77 beds in 2024.[4] Accordingly, based on the acute care Forecasting Method, there is clearly a significant need in the Planning Area for

[4] The Department also uses the phrase "target year" synonymously with the phrase "planning horizon."

the 67 new beds proposed by Kadlec. A step-by-step description of the application of the Forecasting Method to the Planning Area is set forth below.

Emergency Department: Inpatient Admissions

Kadlec has been designated by the Department of Health as a Level III adult trauma center. Kadlec is the largest trauma center in the Planning Area. Kadlec's emergency department visits have increased from 86,004 in 2014 to 100,620 in 2017, as shown in Table 13. In each of the past four years, approximately 62% of Kadlec's inpatient admissions have come from the emergency department (Table 14) As emergency department volumes increase, so do inpatient admissions.

Table 13. Emergency Department Visit Statistics, 2014-2017

Hospital	2014	2015	2016	2017
Kadlec Regional Medical Center	86,004	98,257	95,729	100,620

Source: Kadlec
Excludes: Neonates (DRGs 789-795), Rehab (DRGs 945 and 946), and Chemical Dependency/Substance Abuse (MDC 20).

Table 14. Kadlec Admissions from the Emergency Department, 2014-2017

	2014	2015	2016	2017
Total Inpatient Admits	14,540	14,732	14,281	15,395
Admits from Emergency Department (ED)	9,066	9,225	8,610	9,548
% of Total Inpatient Admits from ED	62.4%	62.6%	60.3%	62.0%

Source: Kadlec
Excludes: Neonates (DRGs 789-795), Rehab (DRGs 945 and 946), and Chemical Dependency/Substance Abuse (MDC 20).

Occupancy Rate

As shown in Table 15, Kadlec's acute care bed occupancy rate has increased significantly in recent years. In 2017, Kadlec operated at a 73.6% occupancy rate for its acute care beds. The 2017 occupancy rate exceeds the optimal hospital occupancy standard of 70% which the Department utilizes with the acute care bed Forecasting Method when applied to a hospital the size of Kadlec. This occupancy growth trend is expected to continue, and, without the project, Kadlec will face increasing occupancy constraints.

Thus, Kadlec is facing significant demand pressures on its available acute care beds. For example, because 62% of its admissions come

from the emergency department (see Table 14), Kadlec often has patients who need to wait for an extended length of time in the emergency department until an acute care bed becomes available. Adding acute care beds will enable Kadlec to move patients from the emergency department into the optimal site of care in a timely manner. This will result in improved care for the patient and will help reduce the overall cost of care.

Table 15. Kadlec Acute Care Occupancy Rate, 2013-2017

	2013	2014	2015	2016	2017
Patient Days	51,108	52,392	55,589	55,138	62,045
ADC	140.0	143.5	152.3	151.1	170.0
Number of Acute Beds	231	231	231	231	231
Occupancy	60.6%	62.1%	65.9%	65.4%	73.6%

*Excludes Neonates (DRGs 789-795), Rehab (DRGs 945 and 946), and Psych (MDC 19)
**Excludes Rehabilitation Unit Utilization
Source: CHARS 2013-2017

Growing Population

From 2010-2015, the Benton-Franklin Planning Area population grew 1.7% annually. As shown in Table 16, this trend is expected to continue during the 5-year periods from 2015-2020 and from 2020-2025, with an estimated average annual population increase of 1.8% during each of those periods.

The population growth is driven primarily by growth in the number of residents age 65 years and older. As shown in Table 16, the number of residents age 65 years and older increased, on average, 5.0% per year from 2010-2015, and is forecasted to grow 4.2% per year during 2015-2020 and 3.7% per year during 2020-2025. This high rate of growth in the number of older residents is important because older residents have a much greater inpatient utilization rate than younger residents. In turn, this translates into much greater demand for inpatient care in the Planning Area. As discussed below in Step 6 of the Forecasting Method and as shown in Table 20, residents age 65 years and older from the Benton-Franklin Planning Area have an inpatient use rate of patient days that is more than five times that of residents whose ages range from 0 to 64 years old.

Table 16. Benton-Franklin Planning Area Population Statistics, 2010-2035

	Year						Average Annual Growth				
	2010	2015	2020	2025	2030		2010-2015	2015-2020	2020-2025	2025-2030	2030-2035
Ages 0-64	227,058	241,914	259,517	279,278	297,956	302,150	1.3%	1.4%	1.5%	1.3%	1.4%
Ages 65+	26,282	33,826	41,760	50,244	57,653	58,709	5.0%	4.2%	3.7%	2.8%	1.8%
Total	**253,340**	**275,740**	**301,277**	**329,522**	**355,609**	**360,859**	**1.7%**	**1.8%**	**1.8%**	**1.5%**	**1.5%**

Source: OFM Small Area Demographic Estimates (SADE) 2000-2017; OFM Medium Series Estimates, 2010-2040 (2017 release)

Planning Area Resident Utilization and In-Migration to Kadlec

Residents from both inside and outside the Planning Area have increasingly relied on Kadlec for inpatient care. Table 17 shows the previous five-year patient day volumes at Kadlec for acute care, segmented by geographic designation.

The Table shows that, in each of the past five years, approximately a quarter of Kadlec's patient days have been attributable to patients who reside *outside* the Planning Area. Thus, Kadlec serves the acute care needs not just of Planning Area residents, but also of a significant number of residents from the surrounding region.

Table 17. Kadlec Patient Days by Patient Origin, 2013-2017

	2013	2014	2015	2016	2017	Average Annual Growth
PA Residents to KRMC	38,627	39,313	41,433	40,736	46,760	4.8%
In-migration to KRMC	12,481	13,079	14,156	14,402	15,285	5.1%
Total Acute Days at KRMC	**51,108**	**52,392**	**55,589**	**55,138**	**62,045**	**4.8%**
PA Residents to KRMC (% of Total)	75.6%	75.0%	74.5%	73.9%	75.4%	
In-migration to KRMC (% of Total)	24.4%	25.0%	25.5%	26.1%	24.6%	

*Excludes Neonates (DRGs 789-795), Rehab (DRGs 945 and 946), and Psych (MDC 19)
**Excludes Rehabilitation Unit Utilization
Source: CHARS 2013-2017
PA = Planning Area

Planning Area Acute Care Bed Need Forecast

As shown in Table 18, there is an estimated shortage of 10 acute care beds in the Planning Area in 2018. Most importantly, however, the Forecasting Method establishes that there will be a need for an additional *77* acute care beds in the Planning Area in 2024, which is the target year under the seven-year planning horizon the Department uses for acute care bed expansion projects. A step-by-step description of the application of the Forecasting Method is set forth below. In addition, Exhibit 15 contains the complete step-by-step application of the acute care bed need methodology to the Benton-Franklin Planning Area.

Table 18. Benton-Franklin Planning Area Bed Need Forecast, 2017-2024

	2017	2018	2019	2020	2021	2022	2023	2024
Benton-Franklin Planning Area	**Forecasts based on Step 4 trendline.**							7-Years
Population 0-64 (1)	246,517	249,958	253,460	259,517	263,292	267,135	271,049	275,033
0-64 Use Rate (2)	199.32	199.73	200.13	200.54	200.95	201.36	201.77	202.18
Population 65+ (1)	37,313	38,885	40,523	41,760	43,303	44,904	46,565	48,287
65+ Use Rate (2)	1035.22	1035.63	1036.04	1036.45	1036.86	1037.26	1037.67	1038.08
Total Population	283,830	288,842	293,984	301,277	306,595	312,039	317,613	323,321
Total Benton-Franklin Planning Area Resident Days	87,762	90,193	92,710	95,326	97,808	100,367	103,008	105,731
Total Days in Benton-Franklin Planning Area Hospitals	90,212	92,796	95,455	98,125	100,729	103,398	106,141	108,951
Available Beds (3)								
Trios Health	101	101	101	101	101	101	101	101
PMH Medical Center	15	15	15	15	15	15	15	15
Kadlec Regional Medical Center	231	231	231	231	231	231	231	231
Lourdes Medical Center	25	25	25	25	25	25	25	25
TOTAL	**372**	**372**	**372**	**372**	**372**	**372**	**372**	**372**
Wtd Occ Std (4)	66.49%	66.49%	66.49%	66.49%	66.49%	66.49%	66.49%	66.49%
Gross Bed Need (TPD/365/Occupancy)--Demand	371.71	382.36	393.31	404.31	415.04	426.04	437.34	448.92
Bed Supply	372.00	372.00	372.00	372.00	372.00	372.00	372.00	372.00
Net Bed Need/Surplus (Demand - Supply)	**-0.29**	**10.36**	**21.31**	**32.31**	**43.04**	**54.04**	**65.34**	**76.92**

(1) OFM SADE Estimates 2008-2017; OFM Medium Series (2017); Washington State projections - OFM Forecast of the State Population by Age and Sex: 2010-2040 (November 2017 Release)
(2) Use Rate Data Source: CHARS. See Steps 5 and 6. Future use rates adjusted per slope trends from Step 4.
(3) Bed supply sources: 2016 DOH Acute Care Bed Survey; Trios Health 2016 Hospital Year-End Report; Lourdes Medical Center 2017 Hospital Year-End Report
(4) Weighted Occupancy: Calculated per 1987 Washington State Health Plan as the sum, across all hospitals in the planning area, of each hospital's occupancy rate times that hospital's percentage of total beds in the area.

Acute Bed Need Methodology

In the case of acute care bed requests, the methodology used to estimate the need for future acute care beds is detailed in the 12-step bed need Forecasting Method in the 1987 Washington State Health Plan ("SHP").[5] Although the SHP was sunset in 1989, the Department of Health has concluded that the methodology remains a reliable tool for predicting the baseline need for acute care beds,

[5] Washington State Health Plan, Vol. II, "Performance Standards for Health Facilities and Services," May 12, 1987. Pages C-40 through C-44 explain the different "steps" required by the bed need methodology.

and thus still uses this methodology consistently in all Certificate of Need evaluations related to acute care bed requests.

The methodology defines how data sets of total patient days and population are created and how they are used mathematically to create bed need forecasts for a defined planning area – in this case, the Benton-Franklin Planning Area. The methodology for each of the steps is set forth below. The actual bed need calculations for each step of the bed need methodology are presented in Exhibit 15 for the model that uses 2008-2017 CHARS patient day statistics. Table 18 above provides the summary bed need projections. The methodology uses population and total patient day statistics for the state, the Health Service Area ("HSA"),[6] and the Benton-Franklin Planning Area.

One important change that occurred in 4Q 2015 was the transition from ICD9 to ICD10. The transition had a significant effect on the MS-DRGs ("DRGs") assigned for certain types of hospital stays. Most importantly, for the purposes of the acute care bed need model, the transition to ICD10 significantly shifted the DRGs assigned for rehabilitation patients. Previously, DRGs 945-946 were used to exclude rehabilitation utilization from the acute care model. Unfortunately, this is no longer an accurate designation.

Table 19 below shows the rehabilitation providers' discharge mix by DRG. The table clearly demonstrates that DRGs 945 and 946 no longer can be used as the only factors to exclude rehab days from the model. By ignoring this change, the model will inaccurately assign patient days to acute care utilization and corresponding use rates, thereby artificially inflating net bed need. To correct for this reallocation of days from DRGs 945 and 946, beginning in Q4 2015, we have excluded all patient day figures, regardless of DRG, from all Washington State rehabilitation units and St. Luke's Rehabilitation Institute, from the acute care bed need model. This exclusion is applied to every step of the methodology [discussed below].

[6] The state is divided into four HSAs by geographic groupings. HSA 1 is composed of Clallam, Island, Jefferson, King, Kitsap, Pierce, San Juan, Skagit, Thurston and Whatcom Counties. HSA 2 is composed of Clark, Cowlitz, Grays Harbor, Klickitat, Lewis, Mason, Pacific, Skamania, Thurston and Wahkiakum Counties. HSA 3 is composed of Benton, Chelan, Douglas, Franklin, Grant, Kittitas, Okanogan and Yakima Counties. HSA 4 is composed of Adams, Asotin, Columbia, Ferry, Garfield, Lincoln, Pend Oreille, Spokane, Stevens, Walla Walla and Whitman Counties.

Table 19. Discharge Mix at Rehab Unit Providers and St. Luke's Rehabilitation Institute, CY2015

MS-DRG	Q1	Q2	Q3	Q4
945	1,332	1,395	1,369	81
946	153	142	160	23
057	3	2	0	410
949	0	0	6	130
560	0	0	0	122
056	0	0	0	101
065	2	0	4	62
092	0	1	1	43
064	0	0	0	42
559	0	0	0	35
561	0	0	0	34
052	0	0	0	34
091	1	0	0	33
939	6	6	7	6
All Other MS-DRGs	5	9	11	368
Total	**1,502**	**1,555**	**1,558**	**1,524**

Source: CHARS 2015

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

Total inpatient patient days for the period 2008-2017 were obtained from the Department of Health Office of Hospital and Patient Data Systems' CHARS database. Patient days were calculated for the Benton-Franklin Planning Area, HSA 3, and the State of Washington as a whole. Patient day figures exclude MDC 19 (psychiatric), DRGs 789-795 (neonate), and all dedicated Washington State inpatient rehabilitation provider utilization. All model calculations use the exclusions listed above.

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

While this step was partially accomplished by limiting the data obtained for Step 1, the remaining data still included non-MDC 19 patient days spent at psychiatric hospitals. Patient days at dedicated psychiatric hospitals were identified for each year and subtracted from each year's total patient days.

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

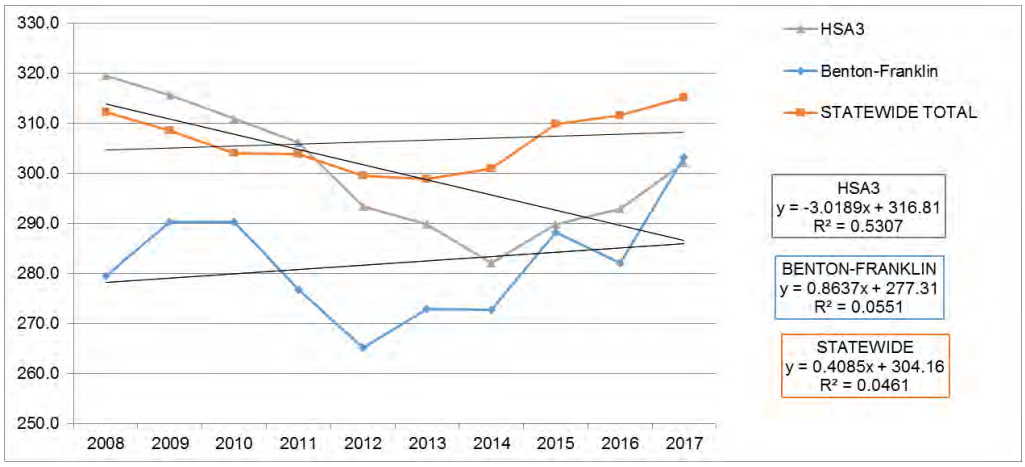
The average use rate (the number of inpatient days per 1,000 population with the exclusions described above applied) was derived by dividing the number of resident patient days in each of the three

study areas by that area's resident population, multiplied by 1,000. Population figures were obtained from OFM for the Benton-Franklin Planning Area, HSA, and State figures. Average use rates were computed for all years of the historic study period: 2008-2017.

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

The use rate estimates described above were graphed for the period 2008-2017. Linear regression analysis, where use rates are regressed on time, was used to fit lines to actual observations, as presented in Figure 1 below. The bed need methodology directs the user to select the slope coefficient of the fitted line for either the HSA or State that would create the "least pronounced" trend adjustment during the forecast period, i.e., whichever trend would result in the least change from base year use rates.[7] In this case, the slope of the fitted line for the State is the least pronounced; that figure, a positive 0.409, is used for the Benton-Franklin Planning Area.

Figure 1. Benton-Franklin Planning Area.
Use Rate Regression Analysis, 2008-2017



Step 5: Using the latest statewide patient origin study, allocate non-psychiatric patient days reported in hospitals back to the hospital planning areas where the patients live.

The previous four steps of the methodology used patient day figures for Planning Area residents, without adjustment for whether their care was received inside or outside of the Planning Area. To determine the need for services for residents of a given planning area

[7] See State Health Plan (1987), pages C-31 and C-32.

and for hospitals in that planning area, patient days must be counted in the planning area where the patients live and then adjusted to reflect patient flows ("migration") into and out of the planning area. Step 5 quantifies resident migration into and out of the Benton-Franklin Planning Area. For this calculation, patient days were separated into two age cohorts: age 0-64 and age 65 and older.

For purposes of the bed need model — to estimate migration into and out of the Planning Area, the analysis divided patient days into two planning areas: the Benton-Franklin Planning Area and the State of Washington, as a whole, minus the Benton-Franklin Planning Area. The analysis indicates there was 25% out-migration of patient days of persons 0-64 years old, and 10% out-migration of patient days of persons 65 years and older from the Planning Area to hospitals in other planning areas. The analysis indicates there also was approximately 0.45% in-migration of patient days for both persons 0-64 years old and 65 years and older from Washington residents living outside the Planning Area to the hospitals in the Planning Area.

Step 6: Compute each hospital planning area's use rate for each of the age groups considered (ages 0-64 and 65+).

This step estimates the age cohort-specific use rates for the year 2017, as defined in Step 3, for the Planning Area and for the rest of Washington State. *Note that the age 65+ use rate of 1,035 patient days per 1,000 residents in the Benton-Franklin Planning Area is more than five times the use rate for residents 0-64 in the Planning Area, which is 199 patient days per 1,000 residents.* Thus, as the population ages, there will be a multiplied impact on demand for inpatient days. Table 20 provides these use rate figures.

Table 20. Inpatient Day Use Rates per 1,000 Residents, Benton-Franklin Planning Area, 2017

Benton-Franklin Planning Area Resident Age Groups	Utilization Rate, Acute Care Patient Days Per 1,000 Residents
Persons 0-64 Years Old	199.32
Persons 65+ Years old	1,035.22

Source: CHARS, 2017, Benton-Franklin Resident Patient Days
Excludes Neonates (DRGs 789-795), Psych (MDC 19) and Rehab (DRGs 945 and 946), and Rehabilitation Unit Utilization

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

As discussed in Step 4, the slope of the statewide use rate was used because it was a smaller adjustment than the HSA 3 rate. Use rates were forecast for the two age groups from 2018 to 2031.

Step 7B: Possible Adjustment for HMO populations.

Not applicable.

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

This step takes projected use rates and population for the two age groups, then calculates total resident patient days for 2018 to 2031.

As noted previously, this analysis uses OFM population estimates and projections.

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

This step uses the 2017 in- and out-migration percentages from Step 5 and applies them to forecast patient days to estimate patient days for residents who remain in the Planning Area, plus residents who in-migrate to Planning Area acute care providers. The in-migration ratio, which is used in Step 9, is calculated based on all resident patient days to the Planning Area hospital divided by all Planning Area resident days, by age cohort.

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

Step 10 calculates Gross Bed Need by dividing the total patient day forecast by 365 to estimate ADC ("average daily census"), then again by the weighted occupancy factor for the Planning Area. The overall weighted occupancy standard for the planning area is 66.49%. This calculation provides Gross Bed Need, by year, as shown in Table 18, the equivalent of "demand" for acute care beds.

Next, Step 10 subtracts the supply of beds in the Benton-Franklin Planning Area's four acute care hospitals: Kadlec, Trios Health, PMH Medical Center, and Lourdes Medical Center. The four Benton-Franklin Planning Area acute care hospitals operate a total of 372 general acute care inpatient beds.

As discussed above, in order to determine need for hospital bed additions, the Department uses a "target year," which it defines as seven years following the last full year for which patient day statistics are available. In this case, 2024 is the "target year." Table 18 shows a forecast shortage of 77 acute care beds in 2024, with growing shortages thereafter.[8]

Step 11: To obtain a bed need forecast for all hospital services, including psychiatric, add the non-psychiatric bed need from step 10 above to the psychiatric inpatient bed need from step 11 of the short-stay psychiatric hospital bed need forecasting method.

Kadlec is not proposing to add psychiatric services at the facility. In Step 10, short stay psychiatric beds were excluded from the bed count total. Therefore, psychiatric services should not be forecasted when evaluating this project.

Step 12: Determine and carry out any necessary adjustments in population, use rates, market shares, and out-of-area use and occupancy rates, following the guidelines in section IV of this Guide.

Adjustments have been made where applicable and described above in accordance with the State Health Plan acute care bed need methodology.

b. The negative impact of and consequences of unmet needs and deficiencies should be identified.

[8] See Exhibit 15. Net bed need will increase from 89 beds in 2025 to 150 beds in 2031.

As discussed above, Kadlec's acute care bed occupancy rate has been increasing and was 73.6% in 2017 (Table 15). Kadlec intends to meet the community demand for inpatient care in a timely manner. As the bed need forecast for the Planning Area demonstrates, the demand for acute care beds is estimated to exceed the bed supply by 10 beds in 2018. After 2018, the demand grows significantly by approximately 10 to 11 beds per year (Table 18). As the largest inpatient provider of acute care hospital services in the Planning Area, if Kadlec does not adequately plan for meeting the future need for more acute care beds, access to inpatient health care services will be limited in the Planning Area and surrounding region. Without this bed expansion, over time more residents of the Planning Area will need to seek care outside the community. The proposed expansion plan will allow Kadlec to continue to provide for the health care needs of the growing community and region.

c. The relationship of the project, if any, to the appropriate service specific Performance Standards of the current State Health Plan should be fully documented in this section.

The State Health Plan is no longer in existence; therefore, this question is not applicable.

d. The relationship of the project, if any, to the appropriate sections of the regional health council Health Systems Plan or Implementation Plan should be fully documented in this section.

The State Health Plan is no longer in existence; therefore this question is not applicable.

2. In the context of the criteria contained in WAC 248-19-370(2)(a) and (2)(b), document the manner in which:

a. Access of low income persons, racial and ethnic minorities, women and mentally handicapped persons and other underserved groups to the services proposed is commensurate with such persons' need for the health services particularly those needs identified in the applicable Health Systems Plan as deserving of priority.

Kadlec has a mission to provide compassionate care to all people in need. This includes a special concern for those who are poor and vulnerable. Patients are treated and cared for regardless of gender, race, ethnicity, disabilities or their ability to pay. Kadlec's 74-year

mission has been, and is, to provide quality health care for every patient.

Given its mission, Kadlec provides charity care to those who are poor and vulnerable and unable to pay for required care. In 2017, Kadlec provided $7.8 million in free and discounted care for those in need in the Planning Area and in the surrounding region. In addition to providing a high level of free and discounted medical care, Kadlec provided approximately $38.5 million in the unfunded cost of government-sponsored medical care; community health, grants and donations; education and research programs; and subsidized services. Overall, Kadlec's community benefit in 2017 was more than $46 million.

With Medicaid expansion and health insurance exchanges, Kadlec's charity care spending reflects the success of more people gaining health insurance coverage. Kadlec is using community benefit investments to create healthier communities, beyond just the need for free and discounted care. Not only does this improve access to care, but, through programs and donations, Kadlec's community benefit connects families with preventive care to keep them healthy, fills gaps in community services, and provides opportunities that bring hope in difficult times.

Table 21 highlights Kadlec's commitment to giving to our communities, with 2017 community benefit in excess of $46 million.

Table 21. Kadlec Community Benefit, 2017

Service	Amount
Unfunded portion of Government-sponsored medical care	$36.7 Million
Free and Discounted Medical Care	$7.8 Million
Community health, grants and donations	$0.6 Million
Education and research programs	$0.8 Million
Subsidized services	$0.4 Million
Total	$46.3 Million

Source: Kadlec

In addition, Table 22 below demonstrates Kadlec has had a significantly higher three-year charity care average, as a percent of total and adjusted revenues, compared to the overall Central Washington Region average. The table shows Kadlec charity care as a percentage of total patient service revenues and adjusted total patient service revenues for 2014-2016. It also provides these

percentage figures for the Central Washington Region average. The Department of Health evaluates hospital charity care performance based on these percentages, and it evaluates a hospital's figures in relation to one of five geographic regions. Kadlec is located within the Central Washington Region. Table 22 shows Kadlec has had significantly higher three-year (2014-2016) charity care averages, as a percentage of both total and adjusted revenues, compared to the Central Washington regional averages.

Table 22. Charity Care Statistics, Kadlec and Central Washington Regional Average, 2014-2016

		% of Total Revenue				% of Adjusted Revenue			
Lic. No	Region/Hospital	2014	2015	2016	3 Year Average, 2014-2016	2014	2015	2016	3 Year Average, 2014-2016
161	Providence/Kadlec Medical Center	1.78%	1.01%	1.23%	1.31%	4.82%	2.71%	3.29%	3.53%
CENTRAL WASHINGTON REGION TOTALS		**1.48%**	**0.86%**	**0.90%**	**1.05%**	**3.68%**	**2.46%**	**2.11%**	**2.67%**

Source: Washington Department of Health, Charity Care Reports, 2014-2016.

b. In the case of the relocation of a facility or service, or the reduction or elimination of a service, the present needs of the defined population for that facility or service, including the needs of underserved groups, will continue to be met by the proposed relocation or by alternative arrangements.

This question is not applicable. No facilities or services will be relocated or eliminated with this project.

c. Applicants should include the following:

Copy of admissions policy

Please refer to Exhibit 16 for the Admissions Policy. In addition, please see Exhibit 17 for the Non-Discrimination and Patient Rights and Responsibilities Policy.

Copy of community service policy

Please refer to Exhibit 18 for a Draft Charity Care Policy.

Reference appropriate access problems identified in State and regional health council planning documents and discuss how this project addresses such problems.

The State Health Plan is no longer in existence; therefore, this question is not applicable.

Other information as appropriate.

This question is not applicable.

3. **Define the population that is expected to be served by the specific project proposed. This may require different definitions for each element of the project.**

   In all cases, provide regional health council population forecasts for the next ten years, broken down into age and sex categories.

   In the case of an existing facility, include a patient origin analysis for at least the most recent twelve month period, if such data is maintained, or provide patient origin data from the last state-wide patient origin study. Patient origin is to be indicated by zip code, zip codes are to be grouped by city and county, and include a zip code map illustrating the service area.

   The population expected to be served can be defined according to specific needs and circumstances of patients (e.g., alcoholism treatment, renal dialysis), or be the number of persons who prefer to receive the services of a particular recognized school or theory of medical care.

   Please see Table 2 for the Benton-Franklin Planning Area definition and Exhibit 6 for the Benton-Franklin Planning Area map. Please also see Table 16 for the Benton-Franklin Planning Area population statistics. For 2017, there are estimated to be 283,830 Planning Area residents.[9]

   Exhibit 19 provides a patient origin analysis for Kadlec acute care inpatients by zip code and county. As shown in the Exhibit 19 analysis, 75.4% of Kadlec acute care patient days come from Benton and Franklin Counties. Table 23 shows the 2017 market share figures of Kadlec for the Planning Area based on discharges and patient days. Further, Table 17 shows Kadlec has had increasing patient days for both Planning Area residents and in-migrants during the past five years. These populations are expected to continue being served by Kadlec, given its responsibilities as the largest hospital provider within the Planning Area and a vital provider for the region.

Table 23. Kadlec Market Share of Planning Area Resident Utilization, 2017

[9] Source: OFM Small Area Demographic Estimates (SADE) 2000-2017; OFM Medium Series Estimates, 2010-2040 (2017 release).

Benton-Franklin Planning Area Resident Utilization		Planning Area Residents at Kadlec		Kadlec Market Share of Planning Area	
Discharges	Patient Days	Discharges	Patient Days	Discharges	Patient Days
21,811	86,717	12,074	46,760	55.4%	53.9%

*Excludes Neonates (DRGs 789-795), Psych (MDC 19) and Rehab (DRGs 945 and 946)
**Excludes Rehabilitation Unit Utilization

4. Provide information on the availability and accessibility of similar existing services to the defined population expected to be served. This section should concentrate on other facilities and services which "compete" with the applicant.

a. Identify all existing providers of services similar to those proposed and include sufficient utilization experience of those providers that demonstrates that such existing services are not available in sufficient supply to meet all or some portion of the forecasted utilization.

Kadlec is one of four acute care hospitals located in the Benton-Franklin County Planning Area. Table 24 identifies the hospitals in the Planning Area.

Table 24. Benton-Franklin County Hospitals

Hospital Name	Planning Area
Kadlec Regional Medical Center, Richland	Benton-Franklin
Lourdes Medical Center, Pasco	Benton-Franklin
PMH Medical Center, Prosser	Benton-Franklin
Trios Health, Kennewick	Benton-Franklin

Source: DOH

Lourdes Medical Center has 25 set-up acute care beds. Because it is designated as a critical access hospital ("CAH"), its acute care bed capacity cannot exceed 25 beds. PMH Medical Center has 15 set-up acute care beds. PMC Medical Center also is designated as a CAH. Therefore, its acute care bed capacity cannot exceed 25 beds. Trios Health has 111 licensed acute care beds. Of those beds, 101 are designated as general medical/surgical beds and 10 are designated as Level II special care nursery beds.

Kadlec's bed capacity and bed designations are set forth in Table 5. Kadlec is a tertiary center for cardiovascular, cancer, neuroscience, orthopedic, and OB services. In addition, Kadlec provides major vascular surgery, interventional radiology and cardiology, advanced electrophysiology, radiation oncology, complete joint replacement

services, Level III adult trauma care, Level II intermediate care nursery, and Level III NICU.

b. If existing services are available to the defined population, demonstrate that such are not accessible to that population. Time and distance factors, among others, are to be analyzed in this section.

As discussed previously, without the project, increasing demand for acute care will effectively close Kadlec to additional acute admits in 2023 and thereafter. If Kadlec does not adequately plan for meeting the future need for acute care hospital beds, access to hospital health care services will be severely limited in the Planning Area. Approval of this expansion plan will allow Kadlec to continue to provide for the health care needs of the rapidly growing Planning Area population, as well as the surrounding region.

c. If existing services are available and accessible to the defined population, justify why the proposed project does not constitute an unnecessary duplication of services.

The bed need Forecasting Method establishes that there is an unmet need of 10 beds in the Planning Area in 2018, with the need growing at a rate of approximately 10 to 11 beds annually until 2024, when the total net need for acute care beds will be 77.[10]

Kadlec is one of four acute care hospitals in the Planning Area. As noted above, two of those hospitals (Lourdes Medical Center and PMH Medical Center) are designated as Critical Access Hospitals, and thus cannot operate more than 25 acute care beds. Therefore, the ability of existing hospitals to absorb further inpatient admissions with their existing bed complements is limited.

Without additional acute care beds, Kadlec will be unable to continue providing necessary acute care bed access to Planning Area residents. Given the need for 77 new acute care beds in 2024 under the Forecasting Method, the proposed project will not result in an unnecessary duplication of services.

5. Provide Utilization Forecasts for each service included in the project. Include the following:

a. **Utilization forecasts for at least three years following project completion.**

[10] See Table 18 and Exhibit 15.

Kadlec is requesting 67 new beds, which will meet almost all of the projected acute care bed need in the Benton-Franklin Planning Area through 2024. The target date for the opening of Kadlec's acute care bed addition project is 10 beds in 2019 (Phase 1), 20 beds in 2020 (Phase 2), and 37 beds in 2021 (Phase 3).

Forecasts for Kadlec's acute care days through 2026 without and with the project are provided in Table 25 and Table 26, respectively.

Table 25. Kadlec Forecast Acute Care Days – Without Project

	Actual	Projected	Forecasts								Average Annual Growth 2019-2026
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	
Total Discharges	15,635	16,166	16,669	17,002	17,342	17,689	18,043	18,043	18,043	18,043	1.2%
Total Patient Days	71,672	74,104	76,410	77,938	79,497	81,087	82,709	82,709	82,709	82,709	1.2%
ALOS	4.58	4.58	4.58	4.58	4.58	4.58	4.58	4.58	4.58	4.58	0.0%
Med/Surg Discharges	14,934	15,362	15,669	15,982	16,302	16,628	16,961	16,961	16,961	16,961	1.2%
Med/Surg Patient Days	62,045	63,822	65,099	66,401	67,729	69,083	70,465	70,465	70,465	70,465	1.2%
Med/Surg ALOS	4.15	4.15	4.15	4.15	4.15	4.15	4.15	4.15	4.15	4.15	0.0%
Med/Surg ADC	169.99	174.86	178.35	181.92	185.56	189.27	193.05	193.05	193.05	193.05	1.2%
Med/Surg Occupancy	73.6%	75.7%	77.2%	78.8%	80.3%	81.9%	83.6%	83.6%	83.6%	83.6%	1.2%

Source: Kadlec
Excludes Normal Newborns (DRG 795) and Rehabilitation Unit.

Table 26. Kadlec Forecast Acute Care Days – With Project

	Actual	Projected	Forecasts								Average Annual Growth 2019-2026
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	
Total Discharges	15,635	16,265	16,874	17,720	18,824	19,307	19,803	20,311	20,867	21,310	3.8%
Total Patient Days	71,672	74,559	77,350	81,229	86,291	88,505	90,778	93,106	95,655	97,685	3.8%
ALOS	4.58	4.58	4.58	4.58	4.58	4.58	4.58	4.58	4.58	4.58	0.0%
Med/Surg Discharges	14,934	15,362	16,030	16,912	18,078	18,557	19,049	19,553	20,109	20,540	4.0%
Med/Surg Patient Days	62,045	63,822	66,598	70,263	75,105	77,096	79,141	81,235	83,547	85,335	4.0%
Med/Surg ALOS	4.15	4.15	4.15	4.15	4.15	4.15	4.15	4.15	4.15	4.15	0.0%
Med/Surg ADC	169.99	174.86	182.46	192.50	205.77	211.22	216.82	222.56	228.90	233.79	4.0%
Med/Surg Occupancy	73.6%	75.7%	75.7%	73.8%	69.0%	70.9%	72.8%	74.7%	76.8%	78.5%	0.5%

Source: Kadlec
Excludes Normal Newborns (DRG 795) and Rehabilitation Unit.

b. The complete quantitative methodology used to construct each utilization forecast.

Table 25: Without the Project

- A key model driver is patient days. The 2018 projected medical/surgical patient day figures are driven by Kadlec's 2018 Projection, which represents an approximate 3% increase over the 2017 figure.

- A growth rate of 2% per year is assumed in medical/surgical patient days until 2023, when maximum sustainable occupancy is reached at 83.6%. Patient days remain constant thereafter.
- The acute care bed total is 231 beds over the forecast period.
- Length of stay ("LOS") is assumed constant at 4.58 days, the 2017 figure.
- Discharges are found by dividing patient days by LOS.
- Total patient days, which include rehab and neonate days, follow medical/surgical patient days, and inflate at the same rate over the forecast period. They become constant for the same reason in 2023 and thereafter.
- Total discharges equal total patient days divided by LOS.

Tables 26 and 27: With the Project

- Table 27, provided below, includes the Kadlec patient day forecasts, With the Project, which are driven off the Benton-Franklin Planning Area acute care bed forecast, provided in Table 18, and included in Table 27 below.

Table 27. Kadlec With Project: Planning Area Bed Share and Kadlec Patient Day Projections.

Kadlec Regional Medical CenterAcute Care Bed Share

	Actual	Projected							
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Kadlec Acute Care Beds	231	231	241	261	298	298	298	298	298	298
All Other Benton-Franklin Acute Be	141	141	141	141	141	141	141	141	141	141
Total Benton-Franklin Acute Beds	372	372	382	402	439	439	439	439	439	439
Kadlec's Share of Beds in Benton-Franklin	62.1%	62.1%	63.1%	64.9%	67.9%	67.9%	67.9%	67.9%	67.9%	67.9%
Kadlec marginal (increased) bed share with project, year-over-year		**0.0%**	**1.0%**	**1.8%**	**3.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**

Source: Table 18.

Utilization Model of Acute Care Days - Kadlec Regional Medical Center

	Actual	Projected							
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Total Days in Benton-Franklin Planning Area Hospitals [*From Acute Care Bed Need Forecast Model*]	90,212	92,796	95,455	98,125	100,729	103,398	106,141	108,951	112,051	114,449
Kadlec Market Share	68.8%	68.8%	69.8%	71.6%	74.6%	74.6%	74.6%	74.6%	74.6%	74.6%
Kadlec Patient Days	62,045	63,822	66,598	70,263	75,105	77,096	79,141	81,235	83,547	85,335
Kadlec ADC	170	175	182	193	206	211	217	223	229	234
Kadlec Beds	231	231	241	261	298	298	298	298	298	298
Kadlec Occupancy	73.59%	75.70%	75.71%	73.76%	69.05%	70.88%	72.76%	74.69%	76.81%	78.45%

*Excludes Neonates (DRGs 789-795), Psych (MDC 19) and Rehab (DRGs 945 and 946)

**Excludes Rehabilitation Unit utilization

Assumes 10 new beds in 2019, 20 additional beds in 2020, and 37 additional beds in 2021

Assumes increases in Kadlec's future market share proportionate to increases in its bed share of total Benton-Franklin acute care beds

- As in the Without Project forecast, medical/surgical patient days are the key driver in the utilization forecast.
- Kadlec acute care patient day forecasts are a function of Planning Area patient day forecasts and Kaldec's share of Planning Area acute care beds (Table 27).
- Planning Area patient day forecasts have been explained above and are provided in Table 18 and Table 27.
- Kadlec's market share of Planning Area hospitals' days for acute care days[11] was 68.8% in 2017 and is expected to remain constant in 2018 (Table 27).
- The 68.8% figure, multiplied by Planning Area patient day figures of 90,212 and 92,796, respectively, yields the Kadlec With Project medical/surgical patient day figures for each year. Please see Tables 26 and 27.
- Kadlec's share of acute care beds was 62.1% in 2017 and 2018 (Table 27). As Kadlec adds beds With the Project (10 acute care beds in 2019, 20 additional beds in 2020 and 37 beds in 2021), its share of acute care beds increases from 62.1% in 2017-2018, to 63.1% in 2019, 64.9% in 2020 and 67.9% in 2021 and thereafter.
- Table 27 shows this incremental increase in Kadlec's bed share over time. This annual increase is used in the forecast of days as follows: over 2018-2019, Kadlec's share of acute care beds increases by 1%. This 1% increase is then added to its patient day market share, creating a 69.8% share figure, Kadlec's share of Planning Area acute care patient days in 2019. Kadlec's share of Planning Area days increases to 71.6% in 2020, then to 74.6% in 2021 and remains constant thereafter (Table 27).
- As stated above, Kadlec' share of Planning Area patient days is multiplied by total Planning Area patient days to estimate Kadlec's acute care patient days With the Project. As Kadlec's share figures increase, its patient days do, as well.
- Length of stay remains constant through the forecast period, at 4.58 days (the same as the Without Project figure).
- Acute care discharges are found by dividing patient days by LOS.
- Kadlec's acute care occupancy rate increases from 73.6% in 2017 to 78.5% in 2026. Please see Table 27.
- Total patient days, With the Project, increase at roughly the same rate as acute care days, remaining about 15% greater than acute care (medical/surgical) days over the forecast.

[11] Acute care means inpatient days excluding Neonates (DRGs 789-795), Psych (MDC 19), and Rehab (DRGs 945,946), as well as Rehabilitation Unit utilization figures.

- Total discharges equal total patient days divided by LOS.

c. Identify and justify all assumptions related to changes in use rate, market share, intensity of service and others.

As detailed above, the utilization model for Kadlec's acute care days uses the *Total Days in Benton-Franklin Planning Area Hospitals* forecast and Kadlec's share of Planning Area acute care beds. The market share figure that drives the Kadlec patient day forecast is the change in Kadlec's share of Planning Area acute care beds, With the Project. Other utilization forecasts drive off changes in that figure. There are no other use rate or intensity of service changes. Such figures as LOS are held constant.

d. Evidence of the number of persons now using the service(s) who will continue to use the service(s). Utilization experience for existing services involved in the project should be reported for up to the last ten years as available. Such utilization should be reported in recognized units of measure appropriate to the service. For hospitals, the workload unit of measure required by the State Hospital Commission should be reported together with the corresponding number of procedures.

It is evident that Kadlec has experienced a strong and increasing base of existing patients during the last 10 years, and Kadlec anticipates these patients will continue to use its services. As the utilization data provided earlier in Table 4 indicates, Kadlec provided 62,045 days of acute patient care in 2017. Please see Tables 3 and 4 for the historic utilization of services at Kadlec.

Based on the current and future need for acute care beds, as well as the underlying demographic data in the Benton-Franklin Planning Area described earlier, it is reasonable to assume that residents will utilize these services.

e. Evidence of the number of persons who will begin to use the service(s).

Table 18 provides forecast patient days, as well as the expected need for additional beds in the Planning Area. There is little question that the beds requested by Kadlec will be utilized, given its history as a key acute care provider in the Planning Area. The addition of 67 acute care beds will enable Kadlec to treat patients in the care setting most appropriate to their needs. It is anticipated that patients in the Benton-Franklin Planning Area needing these services will utilize Kadlec as

necessary. Please see Tables 26 and 27 for the Kadlec With Project forecast and the related text that supports those projections.

6. **Reference all health care facility-related high priority health services needs for your service area which are called for in current health planning documents, including the regional health council HSP and AIP and the State Health Planning and Development Agency SHP. If the resources required for this project, including the manpower, management personnel, capital and operating funds do not address those high priority needs, justify why those resources are not reasonably available to be directed to meet such needs.**

   The State Health Plan is no longer in existence; therefore, this question is not applicable.

7. **As applicable, substantiate the following special needs and circumstances which the proposed project is to serve.**

   a. **The special needs and circumstances of entities such as medical and other health professions schools, multispecialty clinics and specialty centers which provide a substantial portion of their services or resources, or both, to individuals not residing in the health service area in which the entities are located or in adjacent to health service area.**

      Kadlec partners with educational institutions throughout Central and Eastern Washington to serve as a training site for students from various disciplines who wish to prepare themselves for a future in a health care-related field. Students enrolled in the training programs complete a portion of their training at Kadlec. Students in various educational areas, such as imaging, laboratory, nursing, dietary, pharmacy, and surgery receive training at Kadlec. Please refer to Exhibit 25 for a listing of the many health education programs in which Kadlec participates.

   b. **The special needs and circumstances of biomedical and behavioral research projects which are designed to meet a national need and for which local conditions offer special advantages.**

      As a tertiary care referral center, since 2004 Kadlec has maintained an active research department to conduct research relevant to improving patient care. Current research programs and clinical trials at Kadlec include the following:

- Conducting clinical trials in oncology, rheumatology, neurology, diabetes, stroke and behavioral health. These trials are performed at the main campus and Kadlec outpatient clinics.
- Providing innovative new treatments by partnering with pharmaceutical companies, the Providence system, Seattle Cancer Care Alliance, Fred Hutchinson Cancer Research Center, and Pacific Cancer Research Consortium, which is part of the NCI Community Oncology Research Program.

In addition, Kadlec is part of the larger Providence system and, as such, participates in pilot projects to improve clinical outcomes, such as the Institute for Systems Biology genomics programs. Clinical trials help determine the future of medicine, and Kadlec is dedicated to bringing that future into reality.

c. The special needs and circumstances of osteopathic hospitals and non-allopathic services.

This question is not applicable

B. Financial Feasibility

Note: All cost projections are to be in non-inflated dollars. Use the current year dollar value for all proforma data and projections. Do not inflate these dollar amounts.

Note: Capital Expenditure estimates should not include contingencies. Certificate of Need Statute and regulations allow a 12% or $50,000 (whichever is greater) margin before an amendment to an approved Certificate is required.

1. All applicable estimated capital costs (actual or replacement costs if a conversion project).

Table 28. Estimated Capital Cost - Total Project

Question	Total Project
a. Land Purchase	
b. Land Improvements	
c. Building Purchase	
d. Residual Value of Assets Being Replaced	
e. Construction Costs	$150,000
f. Moveable Equipment	$1,153,959
g. Fixed Equipment (which are not included in construction contract)	
h. Architect and Engineering Fees	
i. Consulting Fees	
j. Site Preparation	
k. Supervision and Inspection of Site	
l. Costs associated with securing the Source(s) of financing listed under (2) below	
m. Cost of Financing to include interim interest during construction	
n. Washington State Sales Tax	$112,141
o. Other itemized • Permits and Regulatory Review	
p. Total Estimated Capital Cost (actual / replacement cost)	$1,416,100

2. Provide a copy of a signed nonbinding contractor's estimate of the project's construction cost, movable equipment, fixed equipment, consulting fees, site preparation, and supervision and inspection of site. (Items e, f, g, i, j, and k above)

Please see Exhibit 20 for a copy of the signed letter of reasonableness, providing an estimate for equipment and construction costs.

3. Using the chart below, breakdown the estimated capital cost for each service (cost center) affected by this project. For each service (cost center) provide gross square feet to be impacted by construction and estimated costs for items e, f, g, i, j, and k above. Separately indicate net square feet for each service (cost center). Reference appropriate recognized space planning guidelines you have employed in your space allocation activities.

Table 29. Capital Cost for Each Service

Cost Center/ Service	Estimated Gross Square Feet	Const. Cost/GSF (use e, f, g, i, j and k above)	Total Cost/Bed (use p above)	Total Cost/GSF (Use p above)
Floor 2,3,4 (67 beds)	26,283	$49.61	$21,135.82	$53.88
Cost Center/ Service	Estimated Net Square Feet	Const. Cost/NSF (use e, f, g, i, j and k above)	Total Cost/Bed (use p above)	Total Cost/NSF (Use p above)
Floor 2,3,4 (67 beds)	17,422	$74.85	$21,135.82	$81.28

Source: Kadlec

4. For an existing facility, indicate the increase in capital costs per patient day that would result from this project using the chart below:

Table 30 includes total depreciation and total patient days With the Project. It includes depreciation cost per patient day as well as changes in that figure over the forecast. Table 30 demonstrates these costs per patient day actually fall over the forecast period, With the Project.

Table 30. Capital Costs per Patient Day with Project

	2019	2020	2021	2022	2023	2024	2025	2026
Increase in Depreciation	$ 724,047	$ (130,606)	$ (314,611)	$ (115,126)	$ (157,524)	$ 409,063	$ (1,703,363)	$ (1,707,005)
Increase in Total Capital Expense	$ 57,524	$ 822,593	$ 535,983	$ -	$ -	$ -	$ -	$ -
Increase in Patient Days	2,791	3,880	5,062	2,214	2,273	2,328	2,549	2,030
Increase in Depreciation per Increase in Patient Days	$ 259.45	$ (33.66)	$ (62.16)	$ (52.00)	$ (69.29)	$ 175.75	$ (668.29)	$ (840.72)

Source: Kadlec
Excludes Normal Newborns (DRG 795) and Rehabilitation Unit.

5. Anticipated Sources and Amounts of Financing for the Project (Actual Sources for Conversions).

Table 31. Anticipated Sources and Amounts of Financing

Question	Specify Type	Amount
a. Public Campaign		
b. Bond Issue		
c. Commercial Loans		
d. Government Loans		
e. Grants		
f. Bequests and Donations		
g. Private Foundations		
h. Accumulated Reserves		$1,416,100
i. Internal Loans		
j. Capital Allowance		
k. Other – specify		
l. Total (should equal total project cost)		$1,416,100

Source: Kadlec

6. For projects to be totally or partially funded from capital allowance, please indicate the amount (s) of capital allowance and budget year(s) during which the funds would be used.

The project will not be funded from capital allowance; thus, this question is not applicable.

7. Indicate the anticipated interest rate on the construction loan.

There will be no construction loans.

8. Indicate if you will have a fixed or a variable interest rate on the long-term loan and indicate the rate of interest.

This question is not applicable.

9. Estimated Start - up and Initial Operating Expenses.

a. Total Estimate Start - up costs:
(Expenses incurred prior to opening such as staff training, inventory, etc., reimbursed in accordance with Medicaid guidelines for start - up costs.)

This question is not applicable. This is an existing facility.

b. Estimated Period of time necessary for initial Start-up. (period of time after construction completed but prior to receipt of patients):

This question is not applicable. Kadlec is currently operational.

c. Total Estimated Initial Operating Deficits: (Operating deficits occurring during initial operating period.)

This question is not applicable.

d. Estimated initial operating period (Period of time from receipt of first patient until total revenues equal total expenses.):

This question is not applicable. This is an existing facility that currently has and will continue to have a positive margin.

10. Evidence of Availability of Financing for the Project.

Please submit the following:

a. Copies of letters (s) from lending institutions which indicate a willingness to finance the proposed project (both construction and permanent financing). The letters should include:

i. Status of loan application(s)
ii. Purpose of the loans
iii. Proposed interest rates(s) (Fixed or Variable)
iv. Proposed term (period) of the loan(s)
v. Proposed amount of loan(s)
vi. Verification that the lender has examined the financial position of the borrower and found it to be adequate to support the proposal. The examination should reflect

other project activity, actual or proposed, that might relate to this specific proposal.

This question is not applicable. This project will be financed solely through Kadlec's cash reserves. Please see Exhibit 21 for a letter of financial commitment.

b. Copies of letters from the appropriate source(s) indicating the availability of financing for the initial start-up costs. The letter(s) should include the same items requested in 5(a) above, as applicable.

As noted above, because Kadlec is an existing facility, there will not be any initial start-up costs. Please refer to Exhibit 21 for a letter of financial commitment with respect to the capital cost of the project.

c. Copies of each lease or rental agreement related to the proposed project.

There are no lease or rental agreements related to the proposed project.

d. Amortization schedule(s) for each financing arrangement including long term and any short term start-up or initial operating deficit loans, setting forth the:

i. Principal
ii. Term (number of payment periods) (long term loans may be annualized)
iii. Interest
iv. Outstanding balance at end of each payment period

This question is not applicable.

11. Provide a cost comparison analysis, including a discussion of the advantages and costs, of each of the following alternative financing methods: purchase, lease, Capital Allowance, board-designated reserves, interfund loan, and commercial loan. Provide rationale for choosing the financing method selected.

Note: All tables, statements charts, and columns used in responding to the following information requirements should be clearly labeled as to where the data comes from, and what they are meant to convey.

Kadlec evaluates each capital project in terms of its relative cost, its impact on cash reserves, and the organization's opportunity costs of capital at that

time. As stated above, the project will be financed solely through Kadlec's cash reserves.

12. Cost center budgets, anticipated revenue and operating costs for the period from the current fiscal year through and including three full fiscal years following completion of the project, without inflation, with and without the project. In the "with" scenario, include start - up costs, and the anticipated period of deficit operations before the project is utilized at the break-even point.

Please refer to Exhibit 9 (Proforma and Cost Center Statements of Revenue & Expenses – With Project) and Exhibit 10 (Proforma and Cost Center Statements of Revenue & Expenses – Without Project).

The key assumptions for the financial models include the following:

Utilization:

1. Please see discussion above and detailed in Tables 25, 26 and 27.
2. Outpatient volumes increase at 6% per year.
3. Primary Care volumes increase at 8% per year.
4. Length of Stay is held constant at 2017 levels.

Revenues:

1. Inflation of gross and net revenues was excluded from model.
2. The gross and net revenues are based on actual inpatient, outpatient, and primary care cases.
3. Incremental revenues were calculated on a per case basis, based on actual reimbursement from 2018 cases.
4. Payer mix for both cases and gross revenues was held constant at 2018 rates.
5. Deductions from revenues were calculated based on actuals.
6. Charity care is assumed constant at 1.31% of gross revenues, the Kadlec 3-year average (2014-2016). This is higher than the Central Washington region 3-year (2014-2016) average of 1.05%.

Expenses:

1. FTEs (by account classification, by year), Salaries & Wages, and Benefits were modeled for forecast incremental case volumes based on actuals. It is assumed an FTE works 2,080 hours per year.

2. Non-productive hours are calculated by multiplying productive hours by 1.10; the non-productive factor is thus 10% of productive hours, which is consistent with actual run rate.

3. Benefits as a percentage of wages and salaries are estimated at 8.7%. Beginning in 2017, retirement, health care, and workers comp are recorded at the system level (not locally) so they are excluded from the benefit percentage.

4. Expenses were modeled for the forecast incremental case volumes based on actuals.

    a. Supplies were calculated on a per case basis as a percentage of net revenues from 2018 projections.

    b. Purchased services[12] were calculated on a per case basis based on 2018 projections.

    c. Pharmacy and drugs were calculated on a per case basis based on net revenues from 2017 projections.

5. Annual depreciation expenses included approximately $1.4 million project costs, as well as annual routine capital expenditure depreciation amounts.

6. System overhead allocation is calculated at 6.3% of Total Gross Service Revenues. System overhead allocation includes Human Resources, Finance, Information Technology, Revenue Cycle, and Real Estate.

13. Provide a proforma balance sheet without inflation, with and without the project. However, if there are no capital costs associated with this project, no proforma balance sheets are necessary. If the project is to be totally funded from hospital reserves or capital allowance, a proforma balance sheet with the project is sufficient. Submit these statements for the period from the current fiscal year through and including three full fiscal years following completion of the project.

[12] Purchased services includes utilities, laundry and linen services, laboratory services, and repairs and maintenance.

Provide a narrative of the assumptions used in preparing these statements. Explain any extraordinary changes in financial position.

Kadlec does not maintain a separate balance sheet or cash flow statement. These are kept at the corporate level. Please see Exhibit 22 for Providence Health & Services audited financial statements for 2015 and Providence St. Joseph Health audited financial statements for 2016-2017.

14. **Provide a capital expenditure budget covering each year starting with the first year following the last State Hospital Commission budget submittal up through the third year following completion of the project.**

The State Hospital Commission is no longer in existence; therefore, this question is not applicable.

15. **The expected sources of revenue for the applicant's total operations (e.g., Medicaid, Medicare, Blue Cross, Labor and Industries, etc.) with anticipated percentage of revenue from each source.**

Please see Table 32 for the hospital-wide anticipated inpatient payer mix for Kadlec.

Table 32. Kadlec Anticipated Sources of Revenue

Source	Percent
Medicare	41.6%
Medicaid	23.0%
Commercial	30.2%
Other Government/L&I	2.8%
Self-pay	2.5%
Total	100%

Source: Kadlec, 2017.

*Excludes Normal Newborns

16. **Provide a copy of the latest State Hospital Commission approved rate sheet.**

The State Hospital Commission is no longer in existence; therefore, this question is not applicable.

17. **Provide the complete audited year-end financial reports for the last three full fiscal years. These should include balance sheets, expense**

and revenue statements, statements of changes in financial position, and the accompanying notes.

Please see Exhibit 22 for Providence Health & Services audited financial statements for 2015 and Providence St. Joseph Health audited financial statements for 2016-2017. Kadlec does not maintain a separate balance sheet or cash flow statement. These are kept at the corporate level.

18. The relationship of the project, if any, to the appropriate cost sections of the State Health Plan, regional health council health systems plan or annual implementation plan should be documented.

The State and Regional Health Plans are no longer in existence; therefore, this question is not applicable.

19. Indicate the reduction or addition of FTEs with the salaries, wages, employee benefits for each FTE affected.

Table 33. Kadlec FTEs with Project

	Projected	Forecasts							
	2018	2019	2020	2021	2022	2023	2024	2025	2026
Total Paid FTEs	2,927	3,087	3,273	3,486	3,662	3,849	4,047	4,259	4,475
Total Paid Hours	6,087,349	6,420,666	6,807,004	7,250,615	7,617,033	8,005,451	8,417,102	8,859,109	9,308,170
Average Hourly Wage	$ 44.13	$ 44.13	$ 44.13	$ 44.13	$ 44.13	$ 44.13	$ 44.13	$ 44.13	$ 44.13
Total Salaries	$ 268,634,703	$ 283,344,009	$ 300,393,075	$ 319,969,631	$ 336,139,679	$ 353,280,554	$ 371,446,699	$ 390,952,465	$ 410,769,534
Employee Benefits	$ 23,299,892	$ 24,575,696	$ 26,054,438	$ 27,752,401	$ 29,154,901	$ 30,641,606	$ 32,217,237	$ 33,909,060	$ 35,627,883
Benefits as % Sal & Wages	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%

Source: Kadlec

Table 34. Kadlec FTEs without Project

	Projected	Forecasts							
	2018	2019	2020	2021	2022	2023	2024	2025	2026
Total Paid FTEs	2,927	3,079	3,227	3,384	3,550	3,726	3,887	4,058	4,241
Total Paid Hours	6,087,349	6,404,822	6,712,282	7,038,256	7,383,985	7,750,798	8,084,068	8,440,244	8,820,932
Average Hourly Wage	$ 44.13	$ 44.13	$ 44.13	$ 44.13	$ 44.13	$ 44.13	$ 44.13	$ 44.13	$ 44.13
Total Salaries	$ 268,634,703	$ 282,644,790	$ 296,212,993	$ 310,598,242	$ 325,855,279	$ 342,042,700	$ 356,749,941	$ 372,467,981	$ 389,267,735
Employee Benefits	$ 23,299,892	$ 24,515,050	$ 25,691,881	$ 26,939,578	$ 28,262,889	$ 29,666,897	$ 30,942,522	$ 32,305,818	$ 33,762,936

Source: Kadlec

Please see Exhibit 9 and Exhibit 10, which provide the necessary details by FTE type, with and without the project.

C. Structure and Process (Quality) of Care.

1. Document the following:

a. The availability of sufficient numbers of qualified health manpower and management personnel. If staff availability is a problem, describe the manner in which the problem will be addressed.

We do not anticipate any staffing challenges. Kadlec has an excellent reputation and history of being able to recruit and retain appropriate personnel. Kadlec offers a competitive wage scale, a generous benefit package, and a professionally rewarding work setting.

As part of Providence, Kadlec has multiple resources available to assist with the identification and recruitment of appropriate and qualified personnel:

- Experienced recruitment teams locally and within Providence to recruit qualified manpower
- Strong success in recruiting for critical-to-fill positions with recruiters that offer support on a national level as well as local level
- Career listings on the Providence Web site and job postings on multiple search engines and listing sites (e.g., Indeed, Career Builders, Monster, NW Jobs)
- Educational programs with local colleges and universities, as well as the University of Providence Bachelor of Science in Nursing program (operated by Providence)

Each of these factors has contributed to the ability to maintain a highly qualified employee and management base. Kadlec employs a large number of general and specialty care providers. Kadlec offers an attractive work environment and hours, thus attracting local area residents who are qualified to work in the hospital setting. We do not expect staffing challenges that would disrupt Kadlec's ability to achieve its goals and objectives relative to adding and operating the additional 67 beds.

Kadlec directly employs Kevin Pieper, MD, as its Chief Medical Officer ("CMO"). Please see Exhibit 23 for a copy of the Kadlec CMO job description. Per the Washington State Department of Health Provider Credential Search, Dr. Pieper (#MD00044374) has an active Physician

and Surgeon License with no enforcement actions. Please see Exhibit 24 for a copy of Dr. Pieper's credential details.

b. In the context of the State Health Plan Health Facility / Service General Performance Standard # 2h, document the present and future availability of personnel with qualifications appropriate to the level of intensity of care they are and/or will be providing and with training specific to the technologies they are using.

Kadlec is actively involved in the training of future health care personnel. Kadlec partners with many educational institutions throughout the State of Washington to serve as a training site for students from various disciplines who wish to prepare themselves for a future in a health care related field. Students enrolled in the training programs complete a portion of their training at Kadlec.

These training programs provide a large pool of new health care professionals to the community and serve as an ongoing source for recruiting new personnel to Kadlec. Please see Exhibit 25 for a list of Kadlec Educational Partnerships.

2. Describe the relationship of ancillary and support services to proposed services and the capability of ancillary and support services to meet the service demands of the proposed project.

Kadlec is an existing acute care hospital providing high quality patient services, which includes appropriate ancillary and support services. Kadlec has ancillary services that ensure efficiency and access to state-of-the-art diagnostic and therapeutic services to serve all patients in the best possible manner. The existing ancillary and support services will support the additional bed capacity and will be increased to match needs as we add beds over the 2019-2021 period.

Kadlec utilizes a combination of internal and external arrangements to address the ancillary and support services needed by the hospital. All but two services are provided via an existing internal arrangement. Kadlec has the ability to increase its internal support services, as needed. Kadlec also has two existing external arrangements related to linen services and reference laboratory.[13] Since Kadlec already contracts for linen and reference laboratory services, the hospital will adjust these two services, as needed, after CN approval and as the additional beds become available. No new contracts or new services will be required for the additional 67 beds.

[13] Reference laboratory is defined as the laboratory that receives a specimen from another laboratory and that performs one or more tests on a specimen. Reference laboratories are used for specialized tests that are ordered only occasionally or require specialized equipment.

3. **In the context of the State Health Plan Health Facility / Service General Performance Standard # 2f, document that the facility has and/or will have written policies evidencing a coordination and referral system that assures that patients receive care at the least intensive and restrictive level appropriate to their needs.**

As noted earlier, Kadlec is an existing acute care hospital with a long history of providing high quality patient care. To assist patients and families with obtaining appropriate post-hospital care that will ensure continuity of care, discharge planning will be provided to facilitate timely and appropriate discharge of patients. Policies and procedures are in place to assure coordination and a referral system that assures patients receive appropriate care.

Please see Exhibit 26 for the Patient Transfer to Other Health Care Facilities Policy.

4. **Identify the specific means by which the proposed project will promote continuity in the provision of health care to the defined population and avoid unwarranted fragmentation of services. This section should include the identification of existing and proposed formal working relationships with hospitals, nursing homes, and other health services resources serving your primary service area. This description should include recent, current, and pending cooperative planning activities, shared services agreements, and transfer agreements. Copies of relevant agreements and other documents should be included.**

Kadlec has developed long-term collaborative relationships with other providers to expand program offerings and ensure access and continuity of appropriate care for residents of Benton and Franklin Counties and the other surrounding communities served by Kadlec. Kadlec coordinates patient access to other Providence entities as well as community providers to ensure continuity of care during hospital discharge to other levels of care as well as when other facilities need to transfer patients to Kadlec for more advanced care. Those providers include hospitals, hospice, home care, long-term care facilities, psychiatric care, assisted living, and other providers.

Kadlec will continue to evolve relationships with hospitals, nursing homes, and other health care providers. Kadlec's processes and relationships are reviewed annually to maintain strong inclusive relationships and processes for the care continuum.

5. **In the context of the State Health Plan Health Facility / Service General Performance Standard # 2g, document that your facility ensures**

and/or will ensure effective continuity of care through discharge planning initiated early in the course of treatment.

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

Please see Exhibit 26 for the Patient Transfer to Other Health Care Facilities Policy.

6. **In the context of the State Health Plan Health Facility / Service General Performance Standard # 2c, document that your facility has and/or will have a patient priority policy which requires acceptance of patients according to clinical evidence of medical need and potential benefit to patients.**

Please see Exhibit 27 for the Organizational Plan for Provision of Care Policy.

7. **Fully describe any history of each applicant with respect to the actions noted in Certificate of Need rules and regulations WAC 246-310-230 (5)(a). If there is such history, provide clear, cogent and convincing evidence that the proposed project will be operated in a manner that ensures safe and adequate care to the public to be served and in conformance with applicable federal and state requirements.**

Kadlec has no history of criminal convictions related to ownership/operation of a health care facility, licensure revocations, or other sanctions described in WAC 246-310-230(5)(a). Patient care at Kadlec is and will continue to be provided in conformance with all applicable federal and state requirements.

8. **Demonstrate that services to be provided will be provided (a) in a manner that ensures safe and adequate care, and (b) in accord with applicable federal and state laws, rules and regulations.**

As stated earlier, Kadlec has a history of providing high-quality health care services in a safe and appropriate manner. Kadlec is licensed by the State of Washington Department of Health, is Medicare-certified, and is accredited by The Joint Commission. Kadlec also participates in a variety of other accreditation, licensure and certification reviews by external

agencies (please see a list of current licensures, accreditations, and certifications in section I.E: Facility licensure/accreditation status).

9. Describe how the project complies with the appropriate Quality and Continuity of Care related criteria of the State Health Plan, regional health council health systems plan or annual implementation plan.

The State Health Plan is no longer in existence; therefore, this question is not applicable.

10. In the context of the State Health Plan Health Facility / Service General Performance Standard #2b, document that your facility has and/or will have an active utilization review program.

Kadlec has a comprehensive utilization review program. Utilization Review staff routinely monitor patients on both a concurrent and a retrospective basis to ensure patients meet the criteria for acute care in a hospital setting. When necessary, if a patient is found to no longer meet criteria, Utilization Review clinical staff will work with the patient care team to move the patient to an appropriate level of care.

Please see Exhibit 28 for the Utilization Review Plan.

D. Cost Containment

Document the following:

1. **Exploration of alternatives to the project you have chosen to pursue, including postponing action, shared service arrangements, merger, contract services, and different methods of service provision, including different spatial configurations you have evaluated and rejected. Each alternative should be analyzed by application of the following:**

   - **Decision making criteria (e.g., cost limits, availability, quality of care, legal restrictions, etc.);**
   - **Advantages and disadvantages and whether the sum of either the advantages or the disadvantages outweigh each other by application of the decision making criteria;**
   - **Capital Costs;**
   - **Staffing Impact**

   Kadlec is requesting CN approval to add 67 acute beds to its existing facility. The additional beds will address the significant present and future need in the Benton-Franklin Planning Area for new acute care beds.

   As part of its due diligence, and in deciding to submit this application, Kadlec explored the following alternatives to adding bed capacity in the Planning Area: (1) maintain the status quo; i.e., "do nothing," (2) pursue the requested project: CN approval to add 67 beds to the existing Kadlec facility, or (3) build a new facility to accommodate 77 acute care beds.[14]

   The three alternatives were evaluated using the following decision criteria: access to health care services; quality of care; cost and operating efficiency; staffing impacts; and legal restrictions. Each alternative identifies advantages (A), disadvantages (D), or neutrality (N) in the tables below.

   Based upon evaluation of the above decision criteria, the requested project is the best alternative for addressing the clear and significant need for new acute care beds in the Benton-Franklin Planning Area.

[14] The acute bed need Forecasting Method projects a need of 77 beds in 2024, the seven-year planning horizon. We assume that, with respect to the option of building a new facility, the facility would have to accommodate the full projected need in order to obtain sufficient scale to make the project viable as a stand-alone facility.

Table 35. Alternative Analysis: Access to Health Care Services

Option	Advantages/Disadvantages
Status Quo: "Do nothing"	There is no advantage to maintaining the status quo in terms of improving access, as adding beds in the community will increase access. (D) The principal disadvantage is that the status quo does nothing to address the quantitative need for beds in the Planning Area. Consequently, it does not address the need for beds and does not improve access to care. (D)
Requested Project: Add 67 beds to existing Kadlec facility	The requested project addresses current and future access issues identified in the Planning Area. (A) From an improved access perspective, there are no disadvantages. (A)
Build a new facility to accommodate 77 acute beds	The option provides additional bed capacity to meet current and future access needs. (A) From an improved access perspective, there are no disadvantages. (A)

Table 36. Alternative Analysis: Quality of Care

Option	Advantages/Disadvantages
Status Quo: "Do nothing"	There is no advantage from a quality of care perspective. However, there are no current quality of care issues. (N) The principal disadvantage with maintaining the status quo is driven by the forecasted shortage of beds in the Planning Area. Over time, as access is constrained, there will be adverse impacts on quality of care if patients have to either wait for care or travel to locations outside of the Planning Area. (D)
Requested Project: Add 67 beds to existing Kadlec facility	The requested project meets and promotes quality and continuity of care in the Planning Area. (A) From a quality of care perspective, there are no disadvantages. (A)
Build a new facility to accommodate 77 acute beds	This option meets and promotes quality and continuity of care issues in the planning area. (A) From a quality of care perspective, there are no disadvantages. (A)

Table 37. Alternative Analysis: Cost and Operating Efficiency

Option	Advantages/Disadvantages
Status Quo: "Do nothing"	Under this option, Kadlec would not utilize its unused capacity to add beds to its existing facility. (D) The principal disadvantage is that by maintaining the status quo, there are no improvements to cost efficiencies. (D)
Requested Project: Add 67 beds to existing Kadlec facility	This option allows Kadlec to add needed bed capacity in the community at a low cost, as Kadlec has the built-out space and existing equipment, thus requiring a minimal capital investment in new equipment and minor construction to add the 67 beds. (A) In addition, this option allows Kadlec to apply existing fixed costs over increased bed capacity, contributing to better operating efficiency. (A) From a cost and operating efficiency perspective, there is a very modest capital expenditure of $1,416,100 associated with the project. (N)
Build a new facility to accommodate 77 acute beds	A new hospital facility would require substantially more capital expenditures when compared to the proposed project, requiring new construction or refurbishing an existing facility at considerable expense. (D)

Table 38. Alternative Analysis: Staffing Impacts

Option	Advantages/Disadvantages
Status Quo: "Do nothing"	Principal advantage would be the avoidance of hiring/employing additional hospital staff. (A) There are no disadvantages from a staffing point of view. (N) Will not add to community job growth and economic development. (D)
Requested Project: Add 67 beds to existing Kadlec facility	This option enables more efficient use of staff as they will be located in one care setting allowing for more effective collaboration and coordination between staff members. (A) From a staffing impacts perspective, there are no disadvantages. (N) Will positively contribute to community job growth and economic development. (A)
Build a new facility to accommodate 77 acute beds	There are no advantages from a staffing impacts perspective. (N) The principal disadvantage would be the necessity for Kadlec to hire hospital-based staff in two care settings instead of one. (D) Will positively contribute to community job growth and economic development. (A)

Table 39. Alternative Analysis: Legal Restrictions

Option	Advantages/Disadvantages
Status Quo: "Do nothing"	There are no legal restrictions to continuing present operations. (A)
Requested Project: Add 67 beds to existing Kadlec facility	The principal advantage would be enabling Kadlec to leverage existing licensure and compliance programs. (A) The principal disadvantage is it requires CN approval, which requires time and expense. (D)

Build a new facility to accommodate 77 acute beds	From a legal restrictions perspective, there are no advantages. (N) The principal disadvantage is it not only requires CN approval, but also will require meeting new licensure and complex compliance requirements. (D)

2. The specific ways in which the project will promote staff or system efficiency or productivity.

Kadlec continually looks for ways to improve patient care, operational efficiency, and patient throughput. Kadlec, as with other Providence-affiliated hospitals, has implemented several initiatives during the last several years in order to create additional capacity and ensure patients are served in the right care setting at the right time without expanding licensed acute care beds. These improvements have had a positive impact by opening up capacity temporarily. However, the demand for services continues to increase, and these initiatives are no longer enough to allow Kadlec to fulfill the demand for inpatient services in the Planning Area.

The addition of 67 beds in the existing facility is most effective for staff efficiency and productivity. Locating the beds within the same facility will promote staff flexibility and efficiency in patient flow and throughput. In addition, the project will leverage supply chain and information technology support infrastructure already in place at Kadlec, essentially spreading fixed costs across a larger volume of services.

3. In the case of construction, renovation, or expansion, capital cost reductions achieved by architectural planning and engineering methods and methods of building design and construction. Include an inventory of net and gross square feet for each service and estimated capital costs for each proposed service. Reference appropriate recognized space planning guidelines you have employed in your space allocation activities.

Kadlec will design the expansion in accordance with the standards contained within the Washington State licensing rules and the Facility Guidelines Institute's "Guidelines for Design and Construction of Hospitals and Outpatient Facilities."

4. In the case of construction, renovation or expansion, an analysis of the capital and operating costs of alternative methods of energy consumption, including the rationale for choosing any method other than the least costly. For energy-related projects, document any efforts to obtain a grant under the National Energy Conservation act.

While this project involves the minimal construction of two showers, Kadlec ensures that all construction projects meet the Washington State Building Code and the Washington Energy Code. In addition, the energy conservation program ensures all construction projects are evaluated for alternative electrical and mechanical systems incorporating energy use reduction technology. Kadlec endeavors to exceed energy codes where it is affordable to do so in the interest of reducing ongoing operating costs.

Exhibit 1
Check to DOH

KADLEC

P.O. BOX 389673 SEATTLE, WA 98138-9673
(425) 687-3663

U.S. BANK
HAVRE, MT 59501
24 HOUR BANKING 1-800-673-3555

19-10/1250

CHECK NUMBER	DATE	AMOUNT
97929	05/18/18	**$40,470.00

Kadlec

PAY FORTY THOUSAND FOUR HUNDRED SEVENTY AND 00/100----------

TO THE ORDER OF
DEPT OF HEALTH
111 ISRAEL RD SE
TUMWATER WA 98501-5570

⑈00097929⑈ ⑆125000105⑆ 153595369510⑈

Vendor Number: 32773 Vendor Name: DEPT OF HEALTH Check Number: 97929 Check Date: 05/18/18

Invoice	Inv. Date	PO Number	Comments	Gross	Discounts	Net Amount
CHK1618	05/16/18		ENV EO- APPLICATION KADLEC REGIONAL MED	40,470.00	0.00	40,470.00
					Total Check Amount:	$40,470.00

Exhibit 2
Letter of Intent

KADLEC

June 4, 2018

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

RE: Letter of Intent: Kadlec Regional Medical Center – Add 67 Acute Care Beds

Dear Ms. Sigman:

In accordance with WAC 246-310-080, Kadlec Regional Medical Center respectfully submits this Letter of Intent for the addition of acute care beds in Richland, located in Benton County.

1. Description of proposed service
   Kadlec Regional Medical Center requests certificate of need approval to add 67 acute care beds to its current capacity of 270 licensed beds.

2. Estimated cost of the project
   The estimated cost of the proposed project is $1,416,100.

3. Identification of the service area
   This facility is located within the Benton-Franklin County secondary health services planning area.

Thanks for your assistance in this matter. Please contact me if you have any questions at (509) 897-2081 or Robert.Watilo@providence.org.

Sincerely,

Robert a Watilo

Robert Watilo, Chief Strategy Officer
Kadlec Regional Medical Center
888 Swift Road
Richland, WA 99352

Exhibit 3
Legal Structure of Providence Health & Services

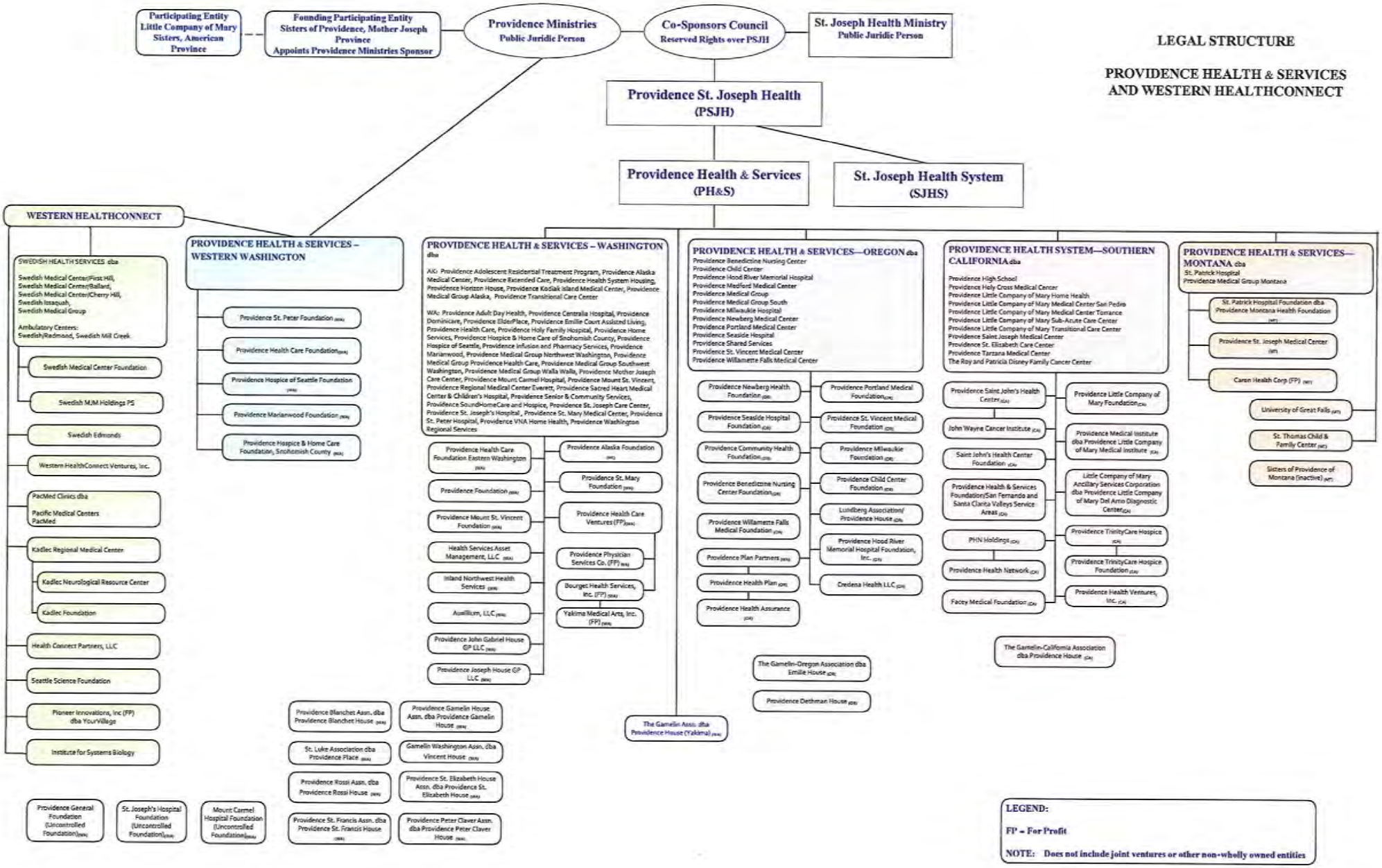

Participating Entity
Little Company of Mary Sisters, American Province
Founding Participating Entity
Sisters of Providence, Mother Joseph Province
Appoints Providence Ministries Sponsor
Providence Ministries
Public Juridic Person
Co-Sponsors Council
Reserved Rights over PSJH
St. Joseph Health Ministry
Public Juridic Person
LEGAL STRUCTURE
PROVIDENCE HEALTH & SERVICES AND WESTERN HEALTHCONNECT
Providence St. Joseph Health (PSJH)
Providence Health & Services (PH&S)
St. Joseph Health System (SJHS)
WESTERN HEALTHCONNECT
SWEDISH HEALTH SERVICES dba
Swedish Medical Center/First Hill,
Swedish Medical Center/Ballard,
Swedish Medical Center/Cherry Hill,
Swedish Issaquah,
Swedish Medical Group
Ambulatory Centers:
Swedish/Redmond, Swedish Mill Creek
Swedish Medical Center Foundation
Swedish MJM Holdings PS
Swedish Edmonds
Western HealthConnect Ventures, Inc.
PacMed Clinics dba
Pacific Medical Centers
PacMed
Kadlec Regional Medical Center
Kadlec Neurological Resource Center
Kadlec Foundation
Health Connect Partners, LLC
Seattle Science Foundation
Pioneer Innovations, Inc (FP)
dba YourVillage
Institute for Systems Biology
Providence General Foundation (Uncontrolled Foundation)
St. Joseph's Hospital Foundation (Uncontrolled Foundation)
Mount Carmel Hospital Foundation (Uncontrolled Foundation)
PROVIDENCE HEALTH & SERVICES – WESTERN WASHINGTON
Providence St. Peter Foundation
Providence Health Care Foundation
Providence Hospice of Seattle Foundation
Providence Marianwood Foundation
Providence Hospice & Home Care Foundation, Snohomish County
PROVIDENCE HEALTH & SERVICES – WASHINGTON dba
AK: Providence Adolescent Residential Treatment Program, Providence Alaska Medical Center, Providence Extended Care, Providence Health System Housing, Providence Horizon House, Providence Kodiak Island Medical Center, Providence Medical Group Alaska, Providence Transitional Care Center
WA: Providence Adult Day Health, Providence Centralia Hospital, Providence Dominicare, Providence ElderPlace, Providence Emilie Court Assisted Living, Providence Health Care, Providence Holy Family Hospital, Providence Home Services, Providence Hospice & Home Care of Snohomish County, Providence Hospice of Seattle, Providence Infusion and Pharmacy Services, Providence Marianwood, Providence Medical Group Northwest Washington, Providence Medical Group Providence Health Care, Providence Medical Group Southwest Washington, Providence Medical Group Walla Walla, Providence Mother Joseph Care Center, Providence Mount Carmel Hospital, Providence Mount St. Vincent, Providence Regional Medical Center Everett, Providence Sacred Heart Medical Center & Children's Hospital, Providence Senior & Community Services, Providence SoundHomeCare and Hospice, Providence St. Joseph Care Center, Providence St. Joseph's Hospital , Providence St. Mary Medical Center, Providence St. Peter Hospital, Providence VNA Home Health, Providence Washington Regional Services
Providence Health Care Foundation Eastern Washington
Providence Foundation
Providence Mount St. Vincent Foundation
Health Services Asset Management, LLC
Inland Northwest Health Services
Asmillion, LLC
Providence John Gabriel House GP LLC
Providence Joseph House GP LLC
Providence Alaska Foundation
Providence St. Mary Foundation
Providence Health Care Ventures (FP)
Providence Physician Services Co. (FP)
Bourget Health Services, Inc. (FP)
Yakima Medical Arts, Inc. (FP)
PROVIDENCE HEALTH & SERVICES—OREGON dba
Providence Benedictine Nursing Center
Providence Child Center
Providence Hood River Memorial Hospital
Providence Medford Medical Center
Providence Medical Group
Providence Medical Group South
Providence Milwaukie Hospital
Providence Newberg Medical Center
Providence Portland Medical Center
Providence Seaside Hospital
Providence Shared Services
Providence St. Vincent Medical Center
Providence Willamette Falls Medical Center
Providence Newberg Health Foundation
Providence Seaside Hospital Foundation
Providence Community Health Foundation
Providence Benedictine Nursing Center Foundation
Providence Willamette Falls Medical Foundation
Providence Plan Partners
Providence Health Plan
Providence Health Assurance
Providence Portland Medical Foundation
Providence St. Vincent Medical Foundation
Providence Milwaukie Foundation
Providence Child Center Foundation
Lundberg Association/ Providence House
Providence Hood River Memorial Hospital Foundation, Inc.
Credena Health LLC
The Gamelin-Oregon Association dba Emilie House
Providence Dethman House
PROVIDENCE HEALTH SYSTEM—SOUTHERN CALIFORNIA dba
Providence High School
Providence Holy Cross Medical Center
Providence Little Company of Mary Home Health
Providence Little Company of Mary Medical Center San Pedro
Providence Little Company of Mary Medical Center Torrance
Providence Little Company of Mary Sub-Acute Care Center
Providence Little Company of Mary Transitional Care Center
Providence Saint Joseph Medical Center
Providence St. Elizabeth Care Center
Providence Tarzana Medical Center
The Roy and Patricia Disney Family Cancer Center
Providence Saint John's Health Center
John Wayne Cancer Institute
Saint John's Health Center Foundation
Providence Health & Services Foundation/San Fernando and Santa Clarita Valleys Service Areas
PHN Holdings
Providence Health Network
Facey Medical Foundation
Providence Little Company of Mary Foundation
Providence Medical Institute dba Providence Little Company of Mary Medical Institute
Little Company of Mary Ancillary Services Corporation dba Providence Little Company of Mary Del Amo Diagnostic Center
Providence TrinityCare Hospice
Providence TrinityCare Hospice Foundation
Providence Health Ventures, Inc.
The Gamelin-California Association dba Providence House
PROVIDENCE HEALTH & SERVICES—MONTANA dba
St. Patrick Hospital
Providence Medical Group Montana
St. Patrick Hospital Foundation dba Providence Montana Health Foundation
Providence St. Joseph Medical Center
Caron Health Corp (FP)
University of Great Falls
St. Thomas Child & Family Center
Sisters of Providence of Montana (Inactive)
The Gamelin Assn. dba Providence House (Yakima)
Providence Blanchet Assn. dba Providence Blanchet House
St. Luke Association dba Providence Place
Providence Rossi Assn. dba Providence Rossi House
Providence St. Francis Assn. dba Providence St. Francis House
Providence Gamelin House Assn. dba Providence Gamelin House
Gamelin Washington Assn. dba Vincent House
Providence St. Elizabeth House Assn. dba Providence St. Elizabeth House
Providence Peter Claver Assn. dba Providence Peter Claver House
LEGEND:
FP = For Profit
NOTE: Does not include joint ventures or other non-wholly owned entities

Exhibit 4
Kadlec Organizational Chart

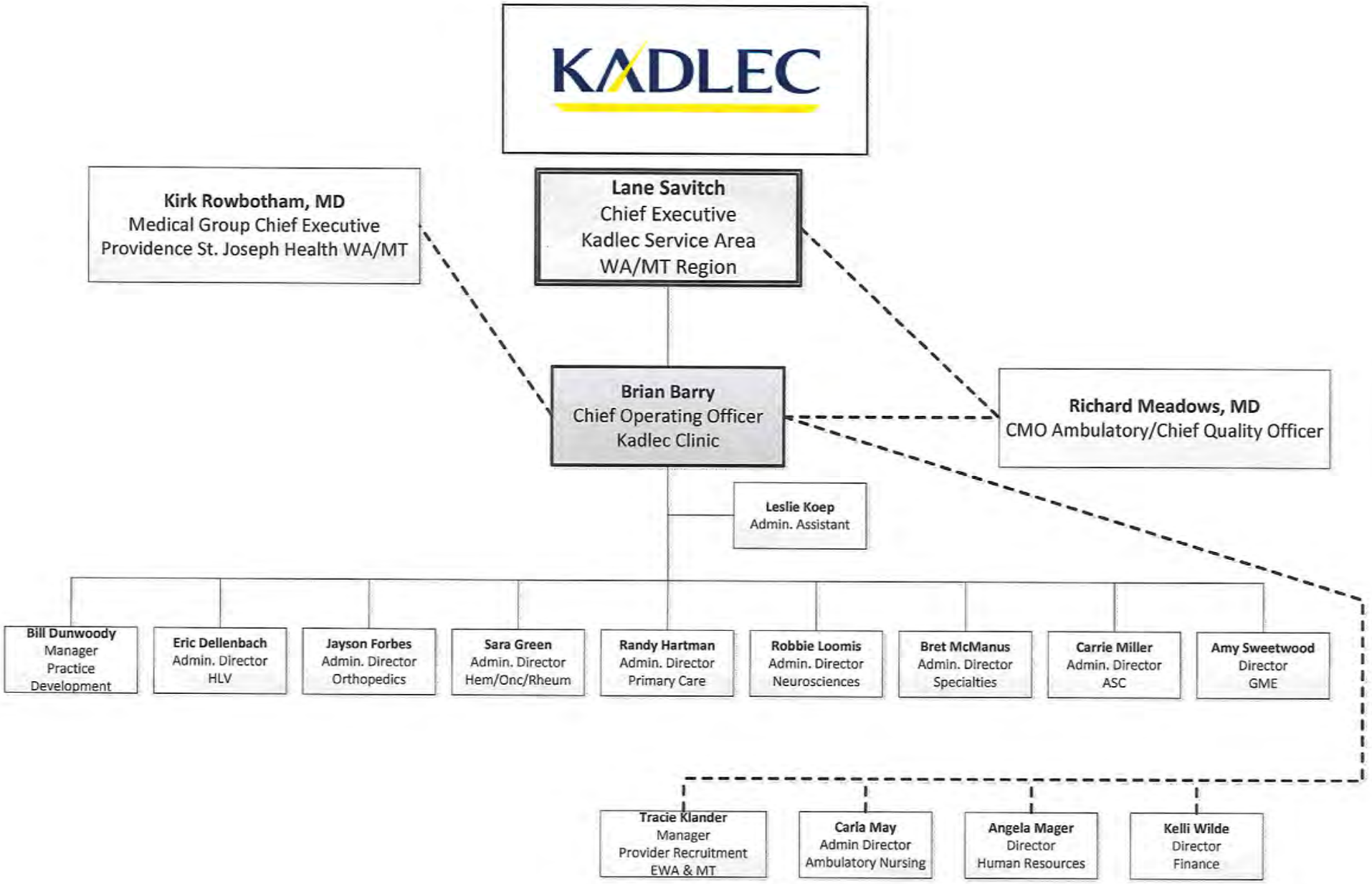

KADLEC
Kirk Rowbotham, MD
Medical Group Chief Executive
Providence St. Joseph Health WA/MT
Lane Savitch
Chief Executive
Kadlec Service Area
WA/MT Region
Brian Barry
Chief Operating Officer
Kadlec Clinic
Richard Meadows, MD
CMO Ambulatory/Chief Quality Officer
Leslie Koep
Admin. Assistant
Bill Dunwoody
Manager
Practice
Development
Eric Dellenbach
Admin. Director
HLV
Jayson Forbes
Admin. Director
Orthopedics
Sara Green
Admin. Director
Hem/Onc/Rheum
Randy Hartman
Admin. Director
Primary Care
Robbie Loomis
Admin. Director
Neurosciences
Bret McManus
Admin. Director
Specialties
Carrie Miller
Admin. Director
ASC
Amy Sweetwood
Director
GME
Tracie Klander
Manager
Provider Recruitment
EWA & MT
Carla May
Admin Director
Ambulatory Nursing
Angela Mager
Director
Human Resources
Kelli Wilde
Director
Finance

Exhibit 5
Facilities Owned, Operated and Managed by Providence Health & Services

Facilities Owned, Operated or Managed by Providence

Facility	Address	City	State	Zip	Owned / Managed
Providence Seward Medical & Care Center	417 1st Avenue	Seward	AK	99664	Managed
Providence Valdez Medical Center	911 Meals Avenue	Valdez	AK	99868	Managed
Providence Valdez Counseling Center	911 Meals Avenue	Valdez	AK	99868	Managed
Providence Horizon House	4140 Folker Street	Anchorage	AK	99508	Owned
Providence Kodiak Island Medical Center	1915 E. Rezanof Drive	Kodiak	AK	99615	Owned
Providence Alaska Medical Center	3200 Providence Drive	Anchorage	AK	99519	Owned
Providence Medical Group Alaska	Various Locations		AK		Owned
Providence Transitional Care Center	4900 Eagle Street	Anchorage	AK	99503	Owned
Providence Extended Care	920 Compassion Circle	Anchorage	AK	99504	
Providence Kodiak Island Mental Health Center	717 E Rezanof Drive	Kodiak	AK	99615	Owned
Providence Residential Treatment Center	3210 West 62nd Avenue	Anchorage	AK	99502	Owned
Providence Home Care	3413 W Pacific Avenue, Ste 201	Burbank	CA	91505	Owned
Providence St. Joseph Medical Center (CA)	501 S Buena Vista Street	Burbank	CA	91505	Owned
Providence Holy Cross Medical Center	15031 Rinaldi Street	Mission Hills	CA	91345	Owned
Providence St. Elizabeth Care Center	10425 Magnolia Blvd	Hollywood	CA	91601	Owned
Providence Tarzana Medical Center	18321 Clark Street	Tarzana	CA	91356	Owned
Providence Little Company of Mary Medical Center- Torrance	4101 Torrance Boulevard	Torrance	CA	90503	Owned
Providence Little Company of Mary Home Health	4101 Torrance Boulevard	Torrance	CA	90503	Owned
Providence Little Company of Mary Medical Center- San Pedro	1300 W 7th Street	San Pedro	CA	90732	Owned
Providence Little Company of Mary Transitional Care Center	4320 Maricopa Street	Torrance	CA	90503	Owned
Providence Little Company of Mary Medical Institute	4101 Torrance Boulevard	Torrance	CA	90503	Owned
Providence Little Company of Mary Subacute Care Center	1300 W. 7th Street	San Pedro	CA	90732	Owned
Providence St. John's Health Center	2121 Santa Monica Boulevard	Santa Monica	CA		
Providence Trinity Care Hospice	5315 Torrance Blvd, Ste B-1	Torrance	CA	90503	Owned
The Roy and Patricia Disney Family Cancer Center	501 S. Buena Vista Street	Burbank	CA	91505	Owned
St. Patrick Hospital	500 W Broadway	Missoula	MT	59802	Owned

Facility	Address	City	State	Zip	Owned / Managed
Providence St. Joseph Medical Center	6- 13th Avenue East	Polson	MT	59860	Owned
Providence Medical Group Montana	Various locations		MT		Owned
Providence Medford Medical Center	1111 Crater Lake Ave	Medford	OR	97504	Owned
Providence Elder at Home	4900 NE Glisan St	Portland	OR	97213	Owned
Providence Portland Medical Center	4805 NE Glisan St	Portland	OR	97123	Owned
Providence Portland Medical Center- SNF	4805 NE Glisan St	Portland	OR	97123	Owned
Providence St. Vincent Medical Center	9205 SW Barnes Rd	Portland	OR	97225	Owned
Providence Hood River Memorial Hospital	811 13th St	Hood River	OR	97031	Owned
Providence Milwaukie Hospital	10150 SE 32nd Avenue	Milwaukie	OR	97222	Owned
Providence Seaside Hospital	725 S Wahanna Rd	Seaside	OR	97138	Owned
Providence Willamette Falls Medical Center	1500 Division Street	Oregon City	OR	97045	Owned
Providence Newberg Medical Center	1001 Providence Dr	Newberg	OR	97132	Owned
Providence Benedictine Nursing Center	540 S. Main Street	Mt. Angel	OR	97362	Owned
Providence Child Center	830 NE 47th Avenue	Portland	OR	97213	Owned
Providence Medical Group	Various locations		OR		Owned
Providence Medical Group South	Various locations		OR		Owned
Providence Home Services	2201 Lind Ave SW, Ste 160	Renton	WA	98057	Owned
Providence Sacred Heart Medical Center & Children's Hospital	101 W. 8th Ave	Spokane	WA	99220	Owned
Providence St. Joseph Care Center	17 East 8th Ave	Spokane	WA	99202	Owned
Providence VNA Home Health	1000 N Argonne, Ste 101	Spokane Valley	WA	99212	Owned
Providence Holy Family Hospital	5633 N Lidgerwood	Spokane	WA	99208	Owned
Providence Centralia Hospital	914 S Scheuber Rd	Centralia	WA	98531	Owned
Providence St. Mary Medical Center	401 W. Poplar Street	Walla Walla	WA	99362	Owned
Providence Marianwood	3725 Providence Point Dr SE	Issaquah	WA	98029	Owned
Providence St. Peter Hospital	413 lilly Rd NE	Olympia	WA	98506	Owned
Providence Hospice of Seattle	425 Pontius Ave N, Ste 300	Seattle	WA	98109	Owned
Providence Regional Medical Center Everett	916 Pacific Avenue	Everett	WA	98201	Owned
Providence Regional Medical Center Everett	1321 Colby Avenue	Everett	WA	98201	Owned
Providence Mount Carmel Hospital - CAH	982 E Columbia	Colville	WA	99114	Owned
Providence Medical Group- Rochester Family Medicine	525 Lilly Rd. NE	Olympia	WA	98506	Owned
Providence St. Joseph Hospital - CAH	500 East Webster Avenue	Chewelah	WA	99109	Owned
Providence Mother Joseph Care Center	3333 Ensign Road NE	Olympia	WA	98506	Owned
Providence Sound HomeCare and Hospice	3432 South Bay Road NE	Olympia	WA	98509	Owned
Providence Hospice and HomeCare of Snohomish	2731 Wetmore Ave, Ste 500	Everett	WA	98201	Owned
Providence Adult Day Health	6018 N. Astor Street	Spokane	WA	99208	Owned

Facility	Address	City	State	Zip	Owned / Managed
Providence DominiCare	110-3rd Street East	Chewelah	WA	99109	Owned
Providence ElderPiace	4515 Martin Luther King Jr. Way South	Seattle	WA	98108	Owned
Providence Emile Court Assisted Living	34 E 8th Avenue	Spokane	WA	99202	Owned
Providence Health Care- Providence Medical Park	16528 E. Desmet Court	Spokane Valley	WA	99016	Owned
Providence Mount Saint Vincent	4831- 35th Avenue SE	Seattle	WA	98126	Owned
Inland Northwest Health Services	601 W 1st Avenue	Spokane	WA	99201	Sole Member
Providence Physician Services Co.	Various locations		WA		Sole Member
Providence Medical Group SW Washington	Various locations		WA		Owned
Providence Medical Group NW Washingt on	Various locations		WA		Owned
Providence Medical Group Providence Health Care	Various locations		WA		Owned
Providence Medical Group Walla Walla	Various locations		WA		Owned

Exhibit 6
Benton Franklin Planning Area Map and Zip Codes

Benton-Franklin Planning Area

County	Zip Code	City
Benton	99320	BENTON CITY
Benton	99336	KENNEWICK
Benton	99337	KENNEWICK
Benton	99338	KENNEWICK
Benton	99345	PATERSON
Benton	99346	PLYMOUTH
Benton	99350	PROSSER
Benton	99352	RICHLAND
Benton	99353	WEST RICHLAND
Benton	99354	RICHLAND
Franklin	99301	PASCO
Franklin	99302	PASCO
Franklin	99326	CONNELL
Franklin	99330	ELTOPIA
Franklin	99335	KAHLOTUS
Franklin	99343	MESA

Benton-Franklin Secondary Planning Area

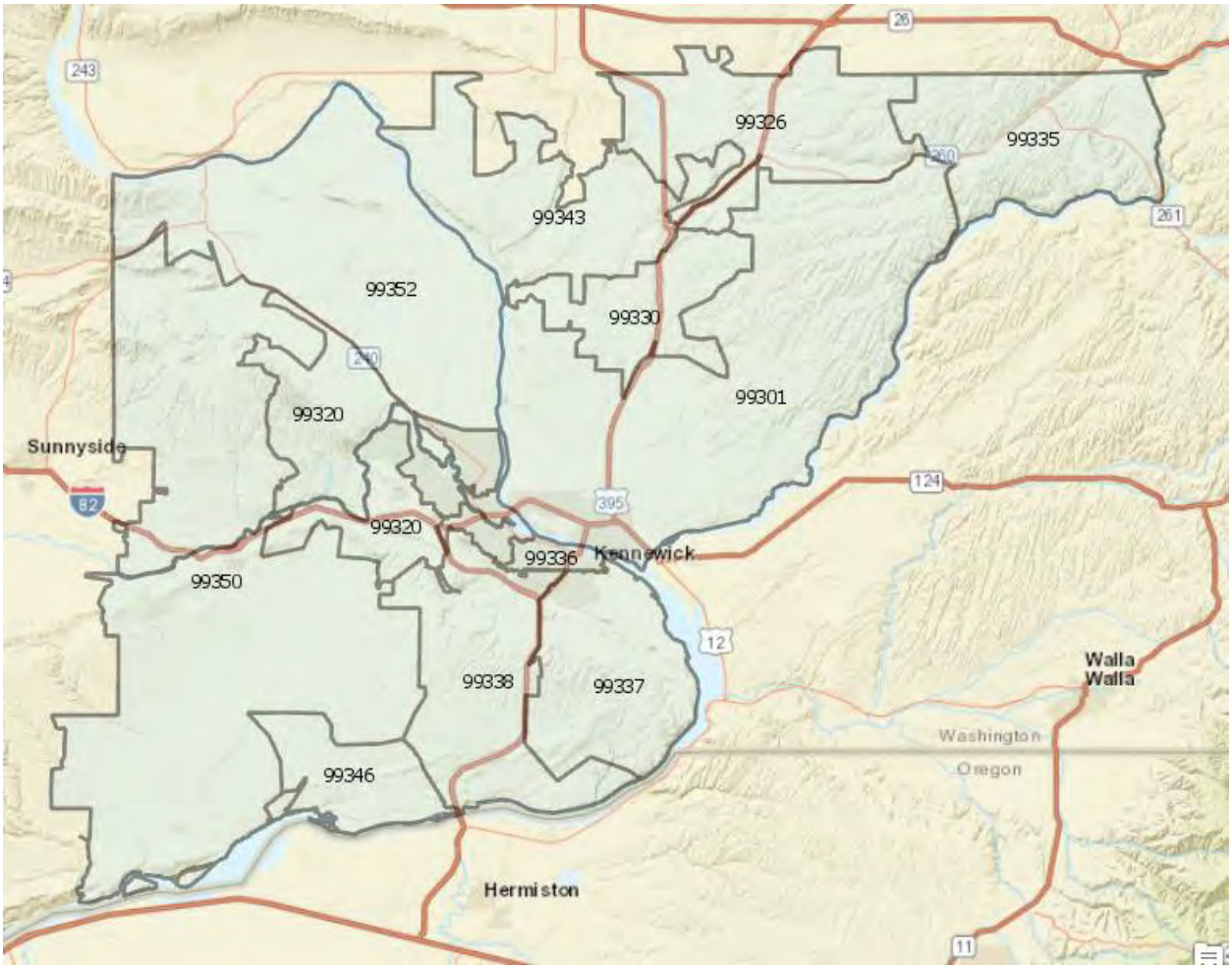


Exhibit 7
Kadlec Active Medical Staff by Specialty

Physicians on Kadlec Medical Staff with Active Privileges, 2018

Description	Medical Staff
Adult Hospitalist	33
Anesthesiology	18
Cardiology	6
Cardiovascular Thoracic Surgery	3
Critical Care Medicine	6
Electrophysiology	1
Emergency Medicine	29
Endocrinology	3
Family Medicine	7
Gastroenterology	7
General Surgery	5
General Surgery & Colon Rectal Surgery	1
Geriatrics	1
Hematology/Oncology	5
Infectious Disease	4
Internal Medicine	2
Interventional Cardiology	4
Interventional Radiology	2
Neonatal ICU Hospitalist	3
Nephrology	6
Neurology	5
Neurosurgery	3
Nuclear Radiology	2
Obstetrics/Gynecology	17
Ophthalmology	1
Oral & Maxillofacial Surgery	2
Orthopedics	10
Otolaryngology	4
Pain Management	4
Pathology	3
Pediatric Hospitalist	3
Pediatrics	1
Perinatology	1
Physical Med + Rehab	2
Plastic Surgery	1
Podiatry	5
Psychiatry	1
Pulmonary and Critical Care Medicine	3
Pulmonary Disease	1
Radiation Oncology	6
Radiology	10
Rheumatology	2
Urology	3
Vascular Surgery	2
Grand Total	**238**

Source: Kadlec Regional Medical Center

Exhibit 8
City of Richland Zoning Confirmation

505 Swift Boulevard, P.O. Box 190 Richland, WA 99352
Telephone 509-942-7390, Fax 509-942-5666

www.ci.richland.wa.us

COMMUNITY DEVELOPMENT DEPARTMENT

Development Permitting Division
840 Northgate Drive
Richland, WA 99352
Telephone 509-942-7794
Fax 509-942-7764

February 23, 2018

Spencer Harris
Sr. Director Finance
Kadlec Health System
888 Swift Blvd.
Richland, WA 99352

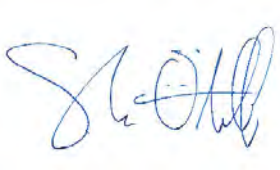
RE: Zoning Confirmation Letter | Kadlec Medical Properties, 888 Swift Blvd., Richland's Central Business District.

Dear Mr. Harris:

This letter is written to apprise you of the zoning regulations in place on the Kadlec Medical Center properties located in the City of Richland's Central Business District (CBD). As stated in Section 23.22.030 of the Richland Municipal Code (RMC), hospitals and medical clinics as well as offices are permitted uses (see attached matrix). No land use approvals or special permit requirements are necessary for this use.

If you have additional questions, please call me at (509) 942-7587.

Sincerely,



Shane O'Neill
Interim Planning Administrator

23.22.030 Commercial use districts permitted land uses.

In the following chart, land use classifications are listed on the vertical axis. Zoning districts are listed on the horizontal axis.

A. If the symbol "P" appears in the box at the intersection of the column and row, the use is permitted, subject to the general requirements and performance standards required in that zoning district.

B. If the symbol "S" appears in the box at the intersection of the column and row, the use is permitted subject to the special use permit provisions contained in Chapter 23.46 RMC.

C. If the symbol "A" appears in the box at the intersection of the column and the row, the use is permitted as an accessory use, subject to the general requirements and performance standards required in the zoning district.

D. If a number appears in the box at the intersection of the column and the row, the use is subject to the general conditions and special provisions indicated in the corresponding note.

E. If no symbol appears in the box at the intersection of the column and the row, the use is prohibited in that zoning district.

Office Uses								
	C-LB	C-1	C-2	C-3	CBD	WF	CR	CW
Medical, Dental and Other Clinics	P	P	P	P	P	P		
Office – Corporate	P		P	P	P	P		P[28]
Office – General	P	P	P	P	P	P		P[28]
Office – Research and Development	P		P	P	P			P[28]
Public/Quasi-Public Uses								
Hospitals	P		P	P	P			

Exhibit 9
Proforma and Cost Center Statements of Revenue & Expenses – With Project

Kadlec Regional Medical Center
Summary Utilization Statistics, With Project, 2015-2026

	Actual	Actual	Actual	Projected	Forecasts								Average Annual Growth 2019-2026
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	
Total Discharges	14,962	14,489	15,635	16,265	16,874	17,720	18,824	19,307	19,803	20,311	20,867	21,310	3.8%
Total Patient Days	64,817	64,354	71,672	74,559	77,350	81,229	86,291	88,505	90,778	93,106	95,655	97,685	3.8%
ALOS	4.33	4.44	4.58	4.58	4.58	4.58	4.58	4.58	4.58	4.58	4.58	4.58	0.0%
Med/Surg Discharges	14,286	13,863	14,934	15,362	16,030	16,912	18,078	18,557	19,049	19,553	20,109	20,540	4.0%
Med/Surg Patient Days	56,031	55,308	62,045	63,822	66,598	70,263	75,105	77,096	79,141	81,235	83,547	85,335	4.0%
Med/Surg ALOS	3.92	3.99	4.15	4.15	4.15	4.15	4.15	4.15	4.15	4.15	4.15	4.15	0.0%
Med/Surg ADC	153.5	151.5	169.99	174.86	182.46	192.50	205.77	211.22	216.82	222.56	228.90	233.79	4.0%
Med/Surg Occupancy	66.5%	65.6%	73.6%	75.7%	75.7%	73.8%	69.0%	70.9%	72.8%	74.7%	76.8%	78.5%	0.5%

Source: Kadlec

*Patient days excludes normal newborns (DRG 795) and the rehabilitation unit. Consequently the proforma patient days will not match Table 4 in the application, which has different exclusions.

Kadlec Regional Medical Center
Statement of Revenue and Expenses, With Project, 2015-2026

	Actual	Actual	Actual	Projected	Forecasts							
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Gross Service Revenues:												
Inpatient	$ 595,145,426	$ 626,181,613	$ 722,080,767	$ 793,720,922	$ 823,429,397	$ 864,733,383	$ 918,617,713	$ 942,187,863	$ 966,388,336	$ 991,166,604	$ 1,018,300,435	$ 1,039,915,330
Outpatient	$ 574,119,894	$ 608,316,915	$ 697,673,087	$ 739,533,472	$ 783,905,480	$ 830,939,809	$ 880,796,198	$ 933,643,970	$ 989,662,608	$ 1,049,042,364	$ 1,111,984,906	$ 1,178,704,000
Primary Care	$ 264,119,950	$ 297,675,123	$ 362,500,204	$ 391,142,480	$ 422,433,879	$ 456,228,589	$ 492,726,876	$ 532,145,026	$ 574,716,628	$ 620,693,958	$ 670,349,475	$ 723,977,433
Total Gross Service Revenues	$ 1,433,385,270	$ 1,532,173,652	$ 1,782,254,058	$ 1,924,396,874	$ 2,029,768,756	$ 2,151,901,781	$ 2,292,140,787	$ 2,407,976,859	$ 2,530,767,571	$ 2,660,902,927	$ 2,800,634,817	$ 2,942,596,764
Revenue Deductions:												
Charity Care	$ 14,547,155	$ 18,810,896	$ 27,165,723	$ 33,499,619	$ 26,589,971	$ 28,189,913	$ 30,027,044	$ 31,544,497	$ 33,153,055	$ 34,857,828	$ 36,688,316	$ 38,548,018
Bad Debt	$ 10,707,404	$ 11,759,853	$ 10,828,964	$ 13,427,496	$ 14,162,730	$ 15,014,914	$ 15,993,433	$ 16,801,680	$ 17,658,453	$ 18,566,474	$ 19,541,454	$ 20,531,995
Medicare & Medicaid	$ 404,284,330	$ 434,036,223	$ 567,032,566	$ 621,213,929	$ 655,228,992	$ 694,654,714	$ 739,925,222	$ 777,318,227	$ 816,956,257	$ 858,965,209	$ 904,072,015	$ 949,898,705
Other	$ 476,870,703	$ 533,334,511	$ 581,448,118	$ 626,435,908	$ 660,736,904	$ 700,494,042	$ 746,145,098	$ 783,852,432	$ 823,823,663	$ 866,185,745	$ 911,671,723	$ 957,883,636
Total Deductions	**$ 906,409,592**	**$ 997,941,483**	**$ 1,186,475,371**	**$ 1,294,576,953**	**$ 1,356,718,597**	**$ 1,438,353,584**	**$ 1,532,090,798**	**$ 1,609,516,836**	**$ 1,691,591,428**	**$ 1,778,575,257**	**$ 1,871,973,508**	**$ 1,966,862,354**
Net Service Revenue	$ 526,975,678	$ 534,232,168	$ 595,778,687	$ 629,819,921	$ 673,050,159	$ 713,548,197	$ 760,049,989	$ 798,460,023	$ 839,176,143	$ 882,327,670	$ 928,661,308	$ 975,734,410
Other Operating Revenue	$ 11,696,024	$ 10,440,898	$ 17,281,465	$ 15,171,275	$ 18,201,990	$ 18,201,990	$ 18,201,990	$ 18,201,990	$ 18,201,990	$ 18,201,990	$ 18,201,990	$ 18,201,990
Total other operating revenue	$ 11,696,024	$ 10,440,898	$ 17,281,465	$ 15,171,275	$ 18,201,990	$ 18,201,990	$ 18,201,990	$ 18,201,990	$ 18,201,990	$ 18,201,990	$ 18,201,990	$ 18,201,990
Total Net Operating Revenues	**$ 538,671,702**	**$ 544,673,066**	**$ 613,060,152**	**$ 644,991,196**	**$ 691,252,149**	**$ 731,750,186**	**$ 778,251,979**	**$ 816,662,013**	**$ 857,378,133**	**$ 900,529,660**	**$ 946,863,298**	**$ 993,936,400**
Expenses from Operations:												
Purchased and Healthcare Expenses	$ 2,539	$ 149,583	$ 67,075	$ 161,739	$ 170,595	$ 180,860	$ 192,646	$ 202,382	$ 212,702	$ 223,640	$ 235,384	$ 247,315
Other Expenses from Operations:												
Salaries & Wages	$ 225,667,161	$ 233,003,561	$ 249,581,338	$ 268,634,703	$ 283,344,009	$ 300,393,075	$ 319,969,631	$ 336,139,679	$ 353,280,554	$ 371,446,699	$ 390,952,465	$ 410,769,534
Employee Benefits	$ 44,996,247	$ 27,973,141	$ 20,949,812	$ 23,299,892	$ 24,575,696	$ 26,054,438	$ 27,752,401	$ 29,154,901	$ 30,641,606	$ 32,217,237	$ 33,909,060	$ 35,627,883
Professional Fees	$ 14,672,691	$ 11,679,231	$ 13,428,253	$ 9,332,237	$ 9,843,232	$ 10,435,508	$ 11,115,588	$ 11,677,327	$ 12,272,793	$ 12,903,876	$ 13,581,496	$ 14,269,932
Supplies	$ 99,268,046	$ 98,253,601	$ 101,512,945	$ 117,521,620	$ 123,956,610	$ 131,415,191	$ 139,979,493	$ 147,053,524	$ 154,552,270	$ 162,499,548	$ 171,032,880	$ 179,702,401
Purchased Services	$ 35,550,353	$ 34,511,213	$ 29,856,920	$ 28,285,455	$ 29,834,248	$ 31,629,402	$ 33,690,683	$ 35,393,282	$ 37,198,103	$ 39,110,878	$ 41,164,706	$ 43,251,312
Depreciation	$ 23,240,726	$ 22,162,200	$ 18,502,224	$ 19,661,977	$ 20,386,023	$ 20,255,418	$ 19,940,806	$ 19,825,680	$ 19,668,156	$ 20,077,219	$ 18,373,855	$ 16,666,851
Interest	$ 9,766,708	$ 10,563,718	$ 11,129,833	$ 11,489,426	$ 11,489,426	$ 11,489,426	$ 11,489,426	$ 11,489,426	$ 11,489,426	$ 11,489,426	$ 11,489,426	$ 11,489,426
Amortization	$ (257,992)	$ (187,853)	$ 435,230	$ 459,270	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Bad Debt	$ 59,715	$ 2,125	$ 112,780	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Taxes and Licenses	$ 8,929,126	$ 10,357,088	$ 5,996,851	$ 8,078,515	$ 8,078,515	$ 8,078,515	$ 8,078,515	$ 8,078,515	$ 8,078,515	$ 8,078,515	$ 8,078,515	$ 8,078,515
Other Expenses	$ 41,795,771	$ 31,878,329	$ 33,080,611	$ 36,101,384	$ 38,078,144	$ 40,369,340	$ 43,000,202	$ 45,173,269	$ 47,476,803	$ 49,918,122	$ 52,539,470	$ 55,202,654
Total Operating Expenses	$ 503,691,090	$ 480,345,937	$ 484,653,874	$ 523,026,217	$ 549,756,497	$ 580,301,172	$ 615,209,391	$ 644,187,984	$ 674,870,927	$ 707,965,159	$ 741,357,257	$ 775,305,821
Total Operating Expenses	**$ 503,691,090**	**$ 480,345,937**	**$ 484,653,874**	**$ 523,026,217**	**$ 549,756,497**	**$ 580,301,172**	**$ 615,209,391**	**$ 644,187,984**	**$ 674,870,927**	**$ 707,965,159**	**$ 741,357,257**	**$ 775,305,821**
Operating Income (Loss)	**$ 34,980,612**	**$ 64,327,130**	**$ 128,406,279**	**$ 121,964,979**	**$ 141,495,651**	**$ 151,449,014**	**$ 163,042,588**	**$ 172,474,028**	**$ 182,507,206**	**$ 192,564,502**	**$ 205,506,041**	**$ 218,630,578**
NONOPERATING INCOME:												
Non-Operating Gain (Loss)	$ (716,072)	$ 6,517,579	$ 11,965,944	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total nonoperating income	$ (716,072)	$ 6,517,579	$ 11,965,944	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
System Overhead Allocation	$ 6,386,000	$ 58,617,000	$ 116,000,000	$ 121,660,800	$ 128,322,434	$ 136,043,711	$ 144,909,652	$ 152,232,835	$ 159,995,691	$ 168,222,877	$ 177,056,758	$ 186,031,624
NET INCOME (LOSS)	**$ 27,878,539**	**$ 12,227,708**	**$ 24,372,222**	**$ 304,179**	**$ 13,173,218**	**$ 15,405,304**	**$ 18,132,935**	**$ 20,241,194**	**$ 22,511,515**	**$ 24,341,625**	**$ 28,449,283**	**$ 32,598,954**

Kadlec Regional Medical Center
Forecast Number of FTE Employees, With Project, 2015-2026

	Actual	Actual	Actual	Projected	Forecasts							
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Total Paid FTEs	3,006	2,687	2,814	2,927	3,087	3,273	3,486	3,662	3,849	4,047	4,259	4,475
Total Paid Hours	6,251,456	5,588,198	5,853,044	6,087,349	6,420,666	6,807,004	7,250,615	7,617,033	8,005,451	8,417,102	8,859,109	9,308,170
Average Hourly Wage	$ 36.10	$ 41.70	$ 42.64	$ 44.13	$ 44.13	$ 44.13	$ 44.13	$ 44.13	$ 44.13	$ 44.13	$ 44.13	$ 44.13
Total Salaries	$ 225,667,161	$ 233,003,561	$ 249,581,338	$ 268,634,703	$ 283,344,009	$ 300,393,075	$ 319,969,631	$ 336,139,679	$ 353,280,554	$ 371,446,699	$ 390,952,465	$ 410,769,534
Employee Benefits	$ 44,996,247	$ 27,973,141	$ 20,949,812	$ 23,299,892	$ 24,575,696	$ 26,054,438	$ 27,752,401	$ 29,154,901	$ 30,641,606	$ 32,217,237	$ 33,909,060	$ 35,627,883
Benefits as % Sal & Wages	19.9%	12.0%	8.4%	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%

Labor Distribution		Actual	Actual	Actual	Projected	Forecasts							
		2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
FTEs	Management Physician FTEs	146	135	133	143	143	144	144	144	144	144	144	144
	RN FTEs	733	605	667	691	736	789	849	899	952	1,008	1,069	1,132
	Physician FTEs	140	138	153	156	164	174	186	195	205	215	227	238
	Non Physician Med Pract FTEs	35	67	88	92	97	103	110	115	121	127	134	141
	Other/Support FTEs	1,621	1,452	1,488	1,564	1,649	1,749	1,862	1,956	2,056	2,162	2,276	2,391
	Nonproductive FTEs	314	277	281	268	283	300	320	336	353	371	391	411
	Agency FTEs	16	14	4	13	14	14	15	16	17	18	19	20
	Total	3,006	2,687	2,814	2,927	3,086	3,274	3,486	3,662	3,848	4,046	4,260	4,477
Hours	Management Physician Hours	304,168	280,109	276,515	296,608	297,440	299,520	299,520	299,520	299,520	299,520	299,520	299,520
	RN Hours	1,525,639	1,257,601	1,386,445	1,437,176	1,530,445	1,641,469	1,766,429	1,870,428	1,980,523	2,097,116	2,224,110	2,355,337
	Physician Hours	290,793	287,027	318,989	324,126	341,878	362,497	385,959	405,501	426,212	448,170	471,754	495,617
	Non Physician Med Pract Hours	73,209	138,530	182,582	191,506	201,994	214,176	228,038	239,584	251,822	264,795	278,729	292,829
	Other/Support Hours	3,371,692	3,020,085	3,094,340	3,252,537	3,430,602	3,637,507	3,872,935	4,069,032	4,276,866	4,497,203	4,733,854	4,973,316
	Nonproductive Hours	652,473	575,469	585,354	558,438	589,022	624,547	664,969	698,638	734,323	772,154	812,786	853,901
	Agency Hours	33,482	29,377	8,819	26,957	28,433	30,148	32,099	33,724	35,447	37,273	39,235	41,219
	Total	6,251,456	5,588,198	5,853,044	6,087,348	6,419,814	6,809,865	7,249,949	7,616,428	8,004,712	8,416,231	8,859,987	9,311,739
Salaries & Wages	Management Physician	$ 17,682,112	$ 14,434,307	$ 14,762,610	$ 16,824,113	$ 16,871,305	$ 16,989,286	$ 16,989,286	$ 16,989,286	$ 16,989,286	$ 16,989,286	$ 16,989,286	$ 16,989,286
	RN	$ 48,776,745	$ 52,589,135	$ 59,224,823	$ 63,456,852	$ 67,575,048	$ 72,477,171	$ 77,994,620	$ 82,586,574	$ 87,447,718	$ 92,595,756	$ 98,203,036	$ 103,997,197
	Physician	$ 46,701,172	$ 51,341,069	$ 61,682,163	$ 66,923,038	$ 70,588,186	$ 74,845,475	$ 79,689,647	$ 83,724,545	$ 88,000,932	$ 92,534,591	$ 97,403,933	$ 102,331,111
	Non Physician Med Pract	$ 7,090,868	$ 9,259,945	$ 11,959,755	$ 13,380,900	$ 14,113,727	$ 14,964,949	$ 15,933,515	$ 16,740,271	$ 17,595,311	$ 18,501,792	$ 19,475,391	$ 20,460,553
	Other/Support	$ 75,364,601	$ 75,477,966	$ 76,781,415	$ 81,812,634	$ 86,291,564	$ 91,494,704	$ 97,416,453	$ 102,348,906	$ 107,576,567	$ 113,118,729	$ 119,071,247	$ 125,094,466
	Nonproductive	$ 24,959,052	$ 26,471,216	$ 24,421,394	$ 24,505,982	$ 25,848,091	$ 27,407,032	$ 29,180,879	$ 30,658,384	$ 32,224,318	$ 33,884,460	$ 35,667,523	$ 37,471,765
	Agency	$ 5,092,611	$ 3,429,923	$ 749,178	$ 1,731,183	$ 1,825,994	$ 1,936,123	$ 2,061,433	$ 2,165,809	$ 2,276,432	$ 2,393,710	$ 2,519,671	$ 2,647,129
	Total	$ 225,667,161	$ 233,003,561	$ 249,581,338	$ 268,634,702	$ 283,113,916	$ 300,114,741	$ 319,265,834	$ 335,213,775	$ 352,110,563	$ 370,018,324	$ 389,330,087	$ 408,991,507
Employee Benefits	Management Physician	$ 3,525,673	$ 1,732,904	$ 1,239,171	$ 1,459,231	$ 1,464,513	$ 1,474,924	$ 1,476,805	$ 1,477,627	$ 1,478,453	$ 1,479,245	$ 1,479,697	$ 1,479,963
	RN	$ 9,725,697	$ 6,313,566	$ 4,971,321	$ 5,503,897	$ 5,865,850	$ 6,292,100	$ 6,779,736	$ 7,182,889	$ 7,609,935	$ 8,062,248	$ 8,553,083	$ 9,059,357
	Physician	$ 9,311,844	$ 6,163,730	$ 5,177,590	$ 5,804,535	$ 6,127,406	$ 6,497,704	$ 6,927,077	$ 7,281,863	$ 7,658,077	$ 8,056,922	$ 8,483,485	$ 8,914,221
	Non Physician Med Pract	$ 1,413,863	$ 1,111,699	$ 1,003,900	$ 1,160,585	$ 1,225,142	$ 1,299,181	$ 1,385,032	$ 1,455,969	$ 1,531,191	$ 1,610,938	$ 1,696,227	$ 1,782,350
	Other/Support	$ 15,027,105	$ 9,061,474	$ 6,445,018	$ 7,095,977	$ 7,490,537	$ 7,943,106	$ 8,467,992	$ 8,901,699	$ 9,361,602	$ 9,849,169	$ 10,370,619	$ 10,897,172
	Nonproductive	$ 4,976,638	$ 3,177,990	$ 2,049,927	$ 2,125,514	$ 2,243,743	$ 2,379,339	$ 2,536,568	$ 2,666,484	$ 2,804,247	$ 2,950,296	$ 3,106,496	$ 3,264,223
	Agency	$ 1,015,426	$ 411,778	$ 62,886	$ 150,153	$ 158,505	$ 168,084	$ 179,191	$ 188,369	$ 198,101	$ 208,419	$ 219,453	$ 230,595
	Total	$ 44,996,247	$ 27,973,141	$ 20,949,812	$ 23,299,892	$ 24,575,696	$ 26,054,438	$ 27,752,401	$ 29,154,901	$ 30,641,606	$ 32,217,237	$ 33,909,060	$ 35,627,883

Source: Kadlec

Kadlec Regional Medical Center
Cost Center, With Project, 2015-2026

	Actual	Actual	Actual	Projected	Forecasts							
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
ALL OTHER												
Total Patient Revenue												
Inpatient Revenue	$ 277,524,593	$ 287,991,510	$ 335,038,237	$ 350,239,362	$ 363,348,601	$ 381,574,506	$ 405,351,646	$ 415,752,272	$ 426,431,035	$ 437,364,759	$ 449,337,904	$ 458,875,748
Outpatient Revenue	$ 460,146,730	$ 461,873,711	$ 533,671,257	$ 587,722,581	$ 622,985,935	$ 660,365,091	$ 699,986,997	$ 741,986,217	$ 786,505,390	$ 833,695,713	$ 883,717,456	$ 936,740,503
Full Time Equivalents	2,266	2,048	2,130	2,243	2,375	2,549	2,748	2,915	3,092	3,279	3,481	3,686
Salaries & Wages	$ 187,886,104	$ 191,304,342	$ 204,595,890	$ 222,700,028	$ 235,502,452	$ 251,625,203	$ 270,094,688	$ 285,506,930	$ 301,854,245	$ 319,190,048	$ 337,804,886	$ 356,766,130
Employee Benefits	$ 42,398,073	$ 24,959,577	$ 17,649,468	$ 19,315,772	$ 20,426,183	$ 21,824,582	$ 23,426,523	$ 24,763,296	$ 26,181,172	$ 27,684,784	$ 29,299,332	$ 30,943,926
Professional Fees	$ 10,397,334	$ 8,180,635	$ 8,868,550	$ 6,406,457	$ 6,783,044	$ 7,207,587	$ 7,689,599	$ 8,115,049	$ 8,567,769	$ 9,049,461	$ 9,566,819	$ 10,101,070
Supplies	$ 59,032,025	$ 54,862,544	$ 59,903,932	$ 68,150,037	$ 72,387,765	$ 77,017,121	$ 82,238,102	$ 87,100,422	$ 92,285,885	$ 97,815,800	$ 103,752,222	$ 109,952,835
Purch Srv - Other	$ 32,589,168	$ 31,597,413	$ 26,155,128	$ 24,138,614	$ 25,515,047	$ 27,080,147	$ 28,860,341	$ 30,401,369	$ 32,038,112	$ 33,776,278	$ 35,641,488	$ 37,557,214
Depreciation	$ 19,123,814	$ 19,166,738	$ 16,010,001	$ 14,861,417	$ 20,160,964	$ 17,432,118	$ 16,943,004	$ 16,728,519	$ 16,467,675	$ 16,769,450	$ 14,950,144	$ 13,138,480
Taxes and Licenses	$ 8,869,257	$ 10,231,750	$ 5,892,624	$ 7,938,851	$ 7,938,851	$ 7,938,851	$ 7,938,851	$ 7,938,851	$ 7,938,851	$ 7,938,851	$ 7,938,851	$ 7,938,851
Other Direct Expenses	$ 40,305,428	$ 29,232,753	$ 31,407,290	$ 34,401,892	$ 36,297,704	$ 38,499,881	$ 41,015,615	$ 43,116,289	$ 45,344,248	$ 47,706,750	$ 50,243,267	$ 52,827,105
Recoveries	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Direct Expenses	**$ 400,601,202**	**$ 369,535,751**	**$ 370,482,883**	**$ 397,913,067**	**$ 425,012,011**	**$ 448,625,488**	**$ 478,206,723**	**$ 503,670,725**	**$ 530,677,955**	**$ 559,931,420**	**$ 589,197,008**	**$ 619,225,610**
Units of Measure (IP Days)	64,817	64,354	71,672	74,559	77,350	81,229	86,291	88,505	90,778	93,106	95,655	97,685
Ratios												
UOS / FTE	28.6	31.4	33.7	33.2	32.6	31.9	31.4	30.4	29.4	28.4	27.5	26.5
Total Revenue / UOS	11,381	11,652	12,121	12,580	12,752	12,827	12,809	13,081	13,361	13,652	13,936	14,287
Total Salaries / UOS	2,899	2,973	2,855	2,987	3,045	3,098	3,130	3,226	3,325	3,428	3,531	3,652
Total Supplies / UOS	911	853	836	914	936	948	953	984	1,017	1,051	1,085	1,126

Source: Kadlec

Kadlec Regional Medical Center
Cost Center, With Project, 2015-2026

	Actual	Actual	Actual	Projected	Forecasts							
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
SURGERY												
Total Patient Revenue												
Inpatient Revenue	$ 106,331,942	$ 114,130,873	$ 123,824,843	$ 149,354,395	$ 154,944,636	$ 162,716,804	$ 172,856,213	$ 177,291,406	$ 181,845,207	$ 186,507,732	$ 191,613,502	$ 195,680,775
Outpatient Revenue	$ 75,705,531	$ 106,383,186	$ 118,895,026	$ 104,371,120	$ 110,633,387	$ 117,271,390	$ 124,307,674	$ 131,766,134	$ 139,672,102	$ 148,052,428	$ 156,935,574	$ 166,351,709
Full Time Equivalents	178	163	172	165	172	182	193	201	209	217	226	235
Salaries & Wages	$ 9,822,535	$ 11,567,501	$ 12,095,322	$ 12,152,864	$ 12,720,572	$ 13,410,786	$ 14,233,462	$ 14,803,140	$ 15,399,934	$ 16,024,656	$ 16,694,693	$ 17,340,517
Employee Benefits	$ 740,159	$ 815,019	$ 881,674	$ 1,054,072	$ 1,103,312	$ 1,163,178	$ 1,234,532	$ 1,283,943	$ 1,335,705	$ 1,389,890	$ 1,448,006	$ 1,504,021
Professional Fees	$ 4,209,796	$ 3,386,416	$ 4,517,834	$ 2,864,401	$ 2,998,208	$ 3,160,890	$ 3,354,793	$ 3,489,065	$ 3,629,728	$ 3,776,973	$ 3,934,899	$ 4,087,118
Supplies	$ 24,077,739	$ 27,200,246	$ 22,869,477	$ 26,316,934	$ 27,546,300	$ 29,040,953	$ 30,822,451	$ 32,056,085	$ 33,348,438	$ 34,701,270	$ 36,152,229	$ 37,550,756
Purch Srv - Other	$ 1,495,668	$ 1,190,405	$ 1,459,281	$ 1,067,538	$ 1,117,407	$ 1,178,037	$ 1,250,303	$ 1,300,345	$ 1,352,769	$ 1,407,647	$ 1,466,504	$ 1,523,235
Depreciation	$ 3,175,534	$ 2,166,336	$ 1,224,422	$ 1,137,461	$ 1,190,596	$ 1,255,198	$ 1,332,197	$ 1,385,517	$ 1,441,374	$ 1,499,846	$ 1,562,559	$ 1,623,005
Taxes and Licenses	$ 1,636	$ 25,391	$ 2,050	$ 26,598	$ 26,598	$ 26,598	$ 26,598	$ 26,598	$ 26,598	$ 26,598	$ 26,598	$ 26,598
Other Direct Expenses	$ 334,850	$ 275,078	$ 313,300	$ 358,930	$ 375,698	$ 396,083	$ 420,380	$ 437,205	$ 454,832	$ 473,282	$ 493,072	$ 512,146
Recoveries	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Direct Expenses	**$ 43,857,918**	**$ 46,626,391**	**$ 43,363,361**	**$ 44,978,799**	**$ 47,078,692**	**$ 49,631,722**	**$ 52,674,716**	**$ 54,781,898**	**$ 56,989,378**	**$ 59,300,162**	**$ 61,778,560**	**$ 64,167,396**
Units of Measure (Minutes)	1,068,711	1,074,811	1,137,613	1,065,853	1,108,487	1,168,633	1,240,322	1,289,965	1,341,970	1,396,409	1,454,797	1,511,075
Ratios												
UOS / FTE	6,008	6,594	6,607	6,473	6,431	6,431	6,431	6,431	6,431	6,431	6,431	6,431
Total Revenue / UOS	170	205	213	238	240	240	240	240	240	240	240	240
Total Salaries / UOS	9	11	11	11	11	11	11	11	11	11	11	11
Total Supplies / UOS	23	25	20	25	25	25	25	25	25	25	25	25

Source: Kadlec

Kadlec Regional Medical Center
Cost Center, With Project, 2015-2026

	Actual	Actual	Actual	Projected	Forecasts							
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
ACUTE												
Total Patient Revenue												
Inpatient Revenue	$ 137,418,561	$ 147,075,451	$ 170,824,464	$ 189,991,535	$ 197,102,799	$ 206,989,659	$ 219,887,853	$ 225,529,797	$ 231,322,620	$ 237,253,749	$ 243,748,725	$ 248,922,643
Outpatient Revenue	$ 11,165,631	$ 12,665,282	$ 14,122,194	$ 15,648,988	$ 16,587,928	$ 17,583,203	$ 18,638,195	$ 19,756,487	$ 20,941,876	$ 22,198,389	$ 23,530,292	$ 24,942,110
Full Time Equivalents	435	359	381	387	403	403	403	403	403	403	403	403
Salaries & Wages	$ 18,827,534	$ 19,804,002	$ 21,380,186	$ 21,870,904	$ 22,727,083	$ 22,727,083	$ 22,727,083	$ 22,727,083	$ 22,727,083	$ 22,727,083	$ 22,727,083	$ 22,727,083
Employee Benefits	$ 1,210,336	$ 1,477,498	$ 1,609,119	$ 1,896,962	$ 1,971,222	$ 1,971,222	$ 1,971,222	$ 1,971,222	$ 1,971,222	$ 1,971,222	$ 1,971,222	$ 1,971,222
Professional Fees	$ 50,976	$ 53,445	$ 41,870	$ 61,380	$ 63,783	$ 67,031	$ 71,196	$ 73,214	$ 75,296	$ 77,442	$ 79,778	$ 81,744
Supplies	$ 2,311,337	$ 2,646,831	$ 2,646,917	$ 2,963,059	$ 3,079,054	$ 3,235,854	$ 3,436,904	$ 3,534,312	$ 3,634,861	$ 3,738,427	$ 3,851,204	$ 3,946,097
Purch Srv - Other	$ 818,419	$ 976,555	$ 1,387,653	$ 1,464,830	$ 1,522,174	$ 1,599,690	$ 1,699,082	$ 1,747,237	$ 1,796,944	$ 1,848,144	$ 1,903,897	$ 1,950,809
Depreciation	$ 615,390	$ 549,661	$ 809,059	$ 955,275	$ 992,672	$ 1,043,223	$ 1,108,041	$ 1,139,444	$ 1,171,861	$ 1,205,250	$ 1,241,609	$ 1,272,202
Taxes and Licenses	$ 9,469	$ 8,756	$ 6,430	$ 9,882	$ 9,882	$ 9,882	$ 9,882	$ 9,882	$ 9,882	$ 9,882	$ 9,882	$ 9,882
Other Direct Expenses	$ 169,503	$ 825,471	$ 256,559	$ 257,438	$ 267,516	$ 281,140	$ 298,607	$ 307,070	$ 315,806	$ 324,804	$ 334,603	$ 342,847
Recoveries	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Direct Expenses	**$ 24,012,964**	**$ 26,342,219**	**$ 28,137,794**	**$ 29,479,730**	**$ 30,633,385**	**$ 30,935,124**	**$ 31,322,017**	**$ 31,509,464**	**$ 31,702,956**	**$ 31,902,254**	**$ 32,119,277**	**$ 32,301,886**
Units of Measure (IP Days)	50,020	49,367	54,027	56,994	59,274	59,274	59,274	59,274	59,274	59,274	59,274	59,274
Ratios												
UOS / FTE	115	137	142	147	147	147	147	147	147	147	147	147
Total Revenue / UOS	2,970	3,236	3,423	3,608	3,605	3,789	4,024	4,138	4,256	4,377	4,509	4,620
Total Salaries / UOS	376	401	396	384	383	383	383	383	383	383	383	383
Total Supplies / UOS	46	54	49	52	52	55	58	60	61	63	65	67

Source: Kadlec

Kadlec Regional Medical Center
Cost Center, With Project, 2015-2026

	Actual	Actual	Actual	Projected	Forecasts							
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
ICU												
Total Patient Revenue												
Inpatient Revenue	$ 31,435,026	$ 33,687,766	$ 46,227,288	$ 49,476,715	$ 51,328,597	$ 53,903,287	$ 57,262,175	$ 58,731,424	$ 60,239,964	$ 61,784,521	$ 63,475,913	$ 64,823,281
Outpatient Revenue	$ 38,949	$ 101,717	$ 581,682	$ 840,705	$ 891,147	$ 944,616	$ 1,001,293	$ 1,061,370	$ 1,125,052	$ 1,192,556	$ 1,264,109	$ 1,339,955
Full Time Equivalents	80	71	90	92	95	95	95	95	95	95	95	95
Salaries & Wages	$ 5,098,313	$ 5,859,628	$ 7,363,510	$ 7,711,180	$ 8,002,712	$ 8,002,712	$ 8,002,712	$ 8,002,712	$ 8,002,712	$ 8,002,712	$ 8,002,712	$ 8,002,712
Employee Benefits	$ 385,686	$ 432,512	$ 543,379	$ 668,825	$ 694,111	$ 694,111	$ 694,111	$ 694,111	$ 694,111	$ 694,111	$ 694,111	$ 694,111
Professional Fees	$ 14,585	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Supplies	$ 818,213	$ 1,101,115	$ 1,256,195	$ 1,342,624	$ 1,393,384	$ 1,463,512	$ 1,554,649	$ 1,595,457	$ 1,637,408	$ 1,680,423	$ 1,727,464	$ 1,765,440
Purch Srv - Other	$ 350,124	$ 469,298	$ 576,824	$ 621,218	$ 644,704	$ 677,152	$ 719,320	$ 738,201	$ 757,612	$ 777,514	$ 799,280	$ 816,851
Depreciation	$ 325,988	$ 279,465	$ 458,728	$ 481,524	$ 499,728	$ 524,879	$ 557,565	$ 572,200	$ 587,246	$ 602,673	$ 619,544	$ 633,164
Taxes and Licenses	$ 540	$ 720	$ 1,090	$ 884	$ 884	$ 884	$ 884	$ 884	$ 884	$ 884	$ 884	$ 884
Other Direct Expenses	$ 95,424	$ 918,758	$ 208,337	$ 98,216	$ 101,929	$ 107,059	$ 113,726	$ 116,711	$ 119,780	$ 122,927	$ 126,368	$ 129,146
Recoveries	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Direct Expenses	**$ 7,088,873**	**$ 9,061,496**	**$ 10,408,063**	**$ 10,924,471**	**$ 11,337,453**	**$ 11,470,309**	**$ 11,642,968**	**$ 11,720,277**	**$ 11,799,754**	**$ 11,881,244**	**$ 11,970,363**	**$ 12,042,307**
Units of Measure (IP Days)	6,010	5,941	8,064	8,160	8,486	8,486	8,486	8,486	8,486	8,486	8,486	8,486
Ratios												
UOS / FTE	75	83	89	89	89	89	89	89	89	89	89	89
Total Revenue / UOS	5,237	5,688	5,805	6,166	6,153	6,463	6,866	7,046	7,231	7,421	7,629	7,796
Total Salaries / UOS	848	986	913	945	943	943	943	943	943	943	943	943
Total Supplies / UOS	136	185	156	165	164	172	183	188	193	198	204	208

Source: Kadlec

Kadlec Regional Medical Center
Cost Center, With Project, 2015-2026

	Actual	Actual	Actual	Projected	Forecasts							
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
PHARMACY												
Total Patient Revenue												
Inpatient Revenue	$ 42,435,305	$ 43,296,014	$ 46,165,934	$ 54,658,915	$ 56,704,764	$ 59,549,128	$ 63,259,826	$ 64,882,964	$ 66,549,509	$ 68,255,844	$ 70,124,392	$ 71,612,883
Outpatient Revenue	$ 27,063,053	$ 27,293,020	$ 30,402,928	$ 30,950,079	$ 32,807,084	$ 34,775,509	$ 36,862,039	$ 39,073,762	$ 41,418,187	$ 43,903,279	$ 46,537,475	$ 49,329,724
Full Time Equivalents	47	45	40	40	42	44	47	49	51	53	55	57
Salaries & Wages	$ 4,032,674	$ 4,468,088	$ 4,146,431	$ 4,199,727	$ 4,391,190	$ 4,627,291	$ 4,911,686	$ 5,099,813	$ 5,296,580	$ 5,502,199	$ 5,723,090	$ 5,933,091
Employee Benefits	$ 261,993	$ 288,535	$ 266,171	$ 364,261	$ 380,868	$ 401,346	$ 426,013	$ 442,330	$ 459,396	$ 477,230	$ 496,389	$ 514,604
Professional Fees	$ -	$ 58,735	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Supplies	$ 13,028,732	$ 12,442,865	$ 14,836,423	$ 18,748,966	$ 19,603,718	$ 20,657,752	$ 21,927,386	$ 22,767,247	$ 23,645,678	$ 24,563,629	$ 25,549,761	$ 26,487,273
Purch Srv - Other	$ 296,975	$ 277,540	$ 278,034	$ 993,255	$ 1,038,537	$ 1,094,376	$ 1,161,637	$ 1,206,130	$ 1,252,666	$ 1,301,296	$ 1,353,537	$ 1,403,204
Depreciation	$ -	$ -	$ 15	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Taxes and Licenses	$ 48,223	$ 90,470	$ 94,656	$ 102,300	$ 102,300	$ 102,300	$ 102,300	$ 102,300	$ 102,300	$ 102,300	$ 102,300	$ 102,300
Other Direct Expenses	$ 890,567	$ 626,270	$ 895,125	$ 984,907	$ 1,029,808	$ 1,085,178	$ 1,151,874	$ 1,195,993	$ 1,242,138	$ 1,290,359	$ 1,342,162	$ 1,391,410
Recoveries												
Total Direct Expenses	**$ 18,559,164**	**$ 18,252,505**	**$ 20,516,855**	**$ 25,393,416**	**$ 26,546,420**	**$ 27,968,243**	**$ 29,680,895**	**$ 30,813,812**	**$ 31,998,757**	**$ 33,237,013**	**$ 34,567,240**	**$ 35,831,882**
Units of Measure (Adj Dischar	37,608	35,452	38,591	37,383	38,878	40,969	43,487	45,152	46,894	48,715	50,671	52,530
Ratios												
UOS / FTE	809	786	953	932	927	927	927	927	927	927	927	927
Total Revenue / UOS	1,848	1,991	1,984	2,290	2,302	2,302	2,302	2,302	2,302	2,302	2,302	2,302
Total Salaries / UOS	107	126	107	112	113	113	113	113	113	113	113	113
Total Supplies / UOS	346	351	384	502	504	504	504	504	504	504	504	504

Source: Kadlec

Kadlec Regional Medical Center
Deductions Summary, With Project, 2015-2026

	Actual	Actual	Actual	Projected	Forecasts							
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Contractual Allowances												
Medicare	$ 363,207,350	$ 383,188,062	$ 514,273,983	$ 566,598,825	$ 597,623,394	$ 633,582,935	$ 674,873,408	$ 708,978,941	$ 745,132,125	$ 783,447,786	$ 824,588,949	$ 866,386,706
Medicaid	$ 41,076,979	$ 50,848,161	$ 52,758,583	$ 54,615,105	$ 57,605,598	$ 61,071,779	$ 65,051,815	$ 68,339,286	$ 71,824,132	$ 75,517,422	$ 79,483,066	$ 83,511,999
Other	$ 476,870,703	$ 533,334,511	$ 581,448,118	$ 626,435,908	$ 660,736,904	$ 700,494,042	$ 746,145,098	$ 783,852,432	$ 823,823,663	$ 866,185,745	$ 911,671,723	$ 957,883,636
Total Contractual Allowances	$ 881,155,032	$ 967,370,734	$ 1,148,480,684	$ 1,247,649,837	$ 1,315,965,897	$ 1,395,148,757	$ 1,486,070,321	$ 1,561,170,659	$ 1,640,779,920	$ 1,725,150,954	$ 1,815,743,738	$ 1,907,782,341
Inpatient	$ 5,783,069	$ 6,187,440	$ 9,328,386	$ 10,704,659	$ 8,496,711	$ 9,007,966	$ 9,595,013	$ 10,079,908	$ 10,593,916	$ 11,138,669	$ 11,723,594	$ 12,317,853
Outpatient	$ 8,764,086	$ 12,623,457	$ 17,837,337	$ 22,794,959	$ 18,093,260	$ 19,181,948	$ 20,432,031	$ 21,464,588	$ 22,559,139	$ 23,719,159	$ 24,964,722	$ 26,230,164
Total Charity Care	$ 14,547,155	$ 18,810,896	$ 27,165,723	$ 33,499,619	$ 26,589,971	$ 28,189,913	$ 30,027,044	$ 31,544,497	$ 33,153,055	$ 34,857,828	$ 36,688,316	$ 38,548,018
Total Bad Debt	$ 10,707,404	$ 11,759,853	$ 10,828,964	$ 13,427,496	$ 14,162,730	$ 15,014,914	$ 15,993,433	$ 16,801,680	$ 17,658,453	$ 18,566,474	$ 19,541,454	$ 20,531,995
Total Deductions From Revenue	$ 906,409,592	$ 997,941,483	$ 1,186,475,371	$ 1,294,576,953	$ 1,356,718,597	$ 1,438,353,584	$ 1,532,090,798	$ 1,609,516,836	$ 1,691,591,428	$ 1,778,575,257	$ 1,871,973,508	$ 1,966,862,354

Source: Kadlec

Kadlec Regional Medical Center
Selected Utilization and Financial Forecasts, With Project, 2015-2026

Volume Indicators

	Actual	Actual	Actual	Projected	Forecasts							
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Admissions	14,962	14,489	15,635	16,265	16,874	17,720	18,824	19,307	19,803	20,311	20,867	21,310
Patient Days	64,817	64,354	71,672	74,559	77,350	81,229	86,291	88,505	90,778	93,106	95,655	97,685
ALOS	4.33	4.44	4.58	4.58	4.58	4.58	4.58	4.58	4.58	4.58	4.58	4.58
Inpatient ED Visits	9,225	8,610	9,548	10,443	10,834	11,377	12,086	12,396	12,715	13,041	13,398	13,682
Outpatient ED Visits	89,032	87,119	91,072	96,536	102,328	108,468	114,976	121,875	129,187	136,939	145,155	153,864
Total ED Visits	98,257	95,729	100,620	106,979	113,162	119,846	127,063	134,271	141,902	149,979	158,553	167,546

Depreciation and Interest per Patient Day

	Actual	Actual	Actual	Projected	Forecasts							
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Total Depreciation	$ 23,240,726	$ 22,162,200	$ 18,502,224	$ 19,661,977	$ 20,386,023	$ 20,255,418	$ 19,940,806	$ 19,825,680	$ 19,668,156	$ 20,077,219	$ 18,373,855	$ 16,666,851
Total Interest	$ 9,766,708	$ 10,563,718	$ 11,129,833	$ 11,489,426	$ 11,489,426	$ 11,489,426	$ 11,489,426	$ 11,489,426	$ 11,489,426	$ 11,489,426	$ 11,489,426	$ 11,489,426
Total Depreciation & Interest	$ 33,007,434	$ 32,725,919	$ 29,632,058	$ 31,151,402	$ 31,875,449	$ 31,744,843	$ 31,430,232	$ 31,315,106	$ 31,157,581	$ 31,566,644	$ 29,863,281	$ 28,156,276
Patient Days	$ 64,817	$ 64,354	$ 71,672	$ 74,559	$ 77,350	$ 81,229	$ 86,291	$ 88,505	$ 90,778	$ 93,106	$ 95,655	$ 97,685
Total Depreciation & Interest / Patient Day	$ 509	$ 509	$ 413	$ 418	$ 412	$ 391	$ 364	$ 354	$ 343	$ 339	$ 312	$ 288

Projected Capital Expenditures

	Actual	Actual	Actual	Projected	Forecasts							
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Project Capital Expenditure					$ 57,524	$ 822,593	$ 535,983					
Routine Capital				$ 15,000,000	$ 15,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 5,000,000
Cost of Securing Sources of Financing												
Total Estimated Capital Expenditure				$ 15,000,000	$ 15,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 5,000,000

Source: Kadlec

*Patient days excludes normal newborns (DRG 795) and the rehabilitation unit. Consequently the proforma patient days will not match Table 4 in the application, which has different exclusions.

Exhibit 10
Proforma and Cost Center Statements of Revenue & Expenses – Without Project

Kadlec Regional Medical Center

Summary Utilization Statistics, Without Project, 2015-2026

	Actual	Actual	Actual	Projected	Forecasts								Average Annual Growth 2019-2026
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	
Total Discharges	14,962	14,489	15,635	16,166	16,669	17,002	17,342	17,689	18,043	18,043	18,043	18,043	1.2%
Total Patient Days*	64,817	64,354	71,672	74,104	76,410	77,938	79,497	81,087	82,709	82,709	82,709	82,709	1.2%
				3.39%	3.11%	2.00%	2.00%	2.00%	2.00%	0.00%	0.00%	0.00%	
ALOS	4.33	4.44	4.58	4.58	4.58	4.58	4.58	4.58	4.58	4.58	4.58	4.58	0.0%
Med/Surg Discharges	14,286	13,863	14,934	15,362	15,669	15,982	16,302	16,628	16,961	16,961	16,961	16,961	1.2%
Med/Surg Patient Days	56,031	55,308	62,045	63,822	65,099	66,401	67,729	69,083	70,465	70,465	70,465	70,465	1.2%
Med/Surg ALOS	3.92	3.99	4.15	4.15	4.15	4.15	4.15	4.15	4.15	4.15	4.15	4.15	0.0%
Med/Surg ADC	153.5	151.5	169.99	174.86	178.35	181.92	185.56	189.27	193.05	193.05	193.05	193.05	1.2%
Med/Surg Occupancy	66.5%	65.6%	73.6%	75.7%	77.2%	78.8%	80.3%	81.9%	83.6%	83.6%	83.6%	83.6%	1.2%

Source: Kadlec

*Patient days excludes normal newborns (DRG 795) and the rehabilitation unit. Consequently the proforma patient days will not match Table 4 in the application, which has different exclusions.

Kadlec Regional Medical Center
Statement of Revenue and Expenses, Without Project, 2015-2026

	Actual	Actual	Actual	Projected	Forecasts							
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Gross Service Revenues:												
Inpatient	$ 595,145,426	$ 626,181,613	$ 722,080,767	$ 793,720,922	$ 818,420,455	$ 834,788,864	$ 851,484,641	$ 868,514,334	$ 885,884,621	$ 885,884,621	$ 885,884,621	$ 885,884,621
Outpatient	$ 574,119,894	$ 608,316,915	$ 697,673,087	$ 739,533,472	$ 783,905,480	$ 830,939,809	$ 880,796,198	$ 933,643,970	$ 989,662,608	$ 1,049,042,364	$ 1,111,984,906	$ 1,178,704,000
Primary Care	$ 264,119,950	$ 297,675,123	$ 362,500,204	$ 391,142,480	$ 422,433,879	$ 456,228,589	$ 492,726,876	$ 532,145,026	$ 574,716,628	$ 620,693,958	$ 670,349,475	$ 723,977,433
Total Gross Service Revenues	$ 1,433,385,270	$ 1,532,173,652	$ 1,782,254,058	$ 1,924,396,874	$ 2,024,759,814	$ 2,121,957,262	$ 2,225,007,715	$ 2,334,303,330	$ 2,450,263,857	$ 2,555,620,943	$ 2,668,219,002	$ 2,788,566,054
Revenue Deductions:												
Charity Care	$ 14,547,155	$ 18,810,896	$ 27,165,723	$ 33,499,619	$ 26,524,354	$ 27,797,640	$ 29,147,601	$ 30,579,374	$ 32,098,457	$ 33,478,634	$ 34,953,669	$ 36,530,215
Bad Debt	$ 10,707,404	$ 11,759,853	$ 10,828,964	$ 13,427,496	$ 14,127,780	$ 14,805,976	$ 15,525,011	$ 16,287,622	$ 17,096,738	$ 17,831,868	$ 18,617,522	$ 19,457,245
Medicare & Medicaid	$ 404,284,330	$ 434,036,223	$ 567,032,566	$ 621,213,929	$ 653,612,057	$ 684,988,334	$ 718,254,017	$ 753,535,699	$ 790,968,879	$ 824,979,166	$ 861,326,909	$ 900,176,102
Other	$ 476,870,703	$ 533,334,511	$ 581,448,118	$ 626,435,908	$ 659,106,377	$ 690,746,406	$ 724,291,723	$ 759,869,986	$ 797,617,833	$ 831,914,013	$ 868,567,298	$ 907,743,060
Total Deductions	**$ 906,409,592**	**$ 997,941,483**	**$ 1,186,475,371**	**$ 1,294,576,953**	**$ 1,353,370,568**	**$ 1,418,338,356**	**$ 1,487,218,353**	**$ 1,560,272,681**	**$ 1,637,781,906**	**$ 1,708,203,681**	**$ 1,783,465,397**	**$ 1,863,906,622**
Net Service Revenue	$ 526,975,678	$ 534,232,168	$ 595,778,687	$ 629,819,921	$ 671,389,246	$ 703,618,906	$ 737,789,362	$ 774,030,649	$ 812,481,950	$ 847,417,262	$ 884,753,604	$ 924,659,432
Other Operating Revenue	$ 11,696,024	$ 10,440,898	$ 17,281,465	$ 15,171,275	$ 18,162,501	$ 18,162,501	$ 18,162,501	$ 18,162,501	$ 18,162,501	$ 18,162,501	$ 18,162,501	$ 18,162,501
Total other operating revenue	$ 11,696,024	$ 10,440,898	$ 17,281,465	$ 15,171,275	$ 18,162,501	$ 18,162,501	$ 18,162,501	$ 18,162,501	$ 18,162,501	$ 18,162,501	$ 18,162,501	$ 18,162,501
Total Net Operating Revenues	**$ 538,671,702**	**$ 544,673,066**	**$ 613,060,152**	**$ 644,991,196**	**$ 689,551,747**	**$ 721,781,407**	**$ 755,951,863**	**$ 792,193,150**	**$ 830,644,452**	**$ 865,579,763**	**$ 902,916,106**	**$ 942,821,933**
Expenses from Operations:												
Purchased and Healthcare Expenses	$ 2,539	$ 149,583	$ 67,075	$ 161,739	$ 170,174	$ 178,343	$ 187,004	$ 196,190	$ 205,936	$ 214,791	$ 224,255	$ 234,369
Other Expenses from Operations:												
Salaries & Wages	$ 225,667,161	$ 233,003,561	$ 249,581,338	$ 268,634,703	$ 282,644,790	$ 296,212,993	$ 310,598,242	$ 325,855,279	$ 342,042,700	$ 356,749,941	$ 372,467,981	$ 389,267,735
Employee Benefits	$ 44,996,247	$ 27,973,141	$ 20,949,812	$ 23,299,892	$ 24,515,050	$ 25,691,881	$ 26,939,578	$ 28,262,889	$ 29,666,897	$ 30,942,522	$ 32,305,818	$ 33,762,936
Professional Fees	$ 14,672,691	$ 11,679,231	$ 13,428,253	$ 9,332,237	$ 9,818,941	$ 10,290,294	$ 10,790,030	$ 11,320,052	$ 11,882,395	$ 12,393,318	$ 12,939,355	$ 13,522,970
Supplies	$ 99,268,046	$ 98,253,601	$ 101,512,945	$ 117,521,620	$ 123,650,717	$ 129,586,500	$ 135,879,721	$ 142,554,331	$ 149,635,962	$ 156,070,048	$ 162,946,336	$ 170,295,849
Purchased Services	$ 35,550,353	$ 34,511,213	$ 29,856,920	$ 28,285,455	$ 29,760,625	$ 31,189,267	$ 32,703,938	$ 34,310,403	$ 36,014,831	$ 37,563,407	$ 39,218,412	$ 40,987,315
Depreciation	$ 23,240,726	$ 22,162,200	$ 18,502,224	$ 19,661,977	$ 20,377,806	$ 20,129,687	$ 19,738,506	$ 19,623,380	$ 19,465,856	$ 19,874,919	$ 18,171,555	$ 16,472,768
Interest	$ 9,766,708	$ 10,563,718	$ 11,129,833	$ 11,489,426	$ 11,489,426	$ 11,489,426	$ 11,489,426	$ 11,489,426	$ 11,489,426	$ 11,489,426	$ 11,489,426	$ 11,489,426
Amortization	$ (257,992)	$ (187,853)	$ 435,230	$ 459,270	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Bad Debt	$ 59,715	$ 2,125	$ 112,780	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Taxes and Licenses	$ 8,929,126	$ 10,357,088	$ 5,996,851	$ 8,078,515	$ 8,078,515	$ 8,078,515	$ 8,078,515	$ 8,078,515	$ 8,078,515	$ 8,078,515	$ 8,078,515	$ 8,078,515
Other Expenses	$ 41,795,771	$ 31,878,329	$ 33,080,611	$ 36,101,384	$ 37,984,177	$ 39,807,586	$ 41,740,796	$ 43,791,165	$ 45,966,566	$ 47,943,049	$ 50,055,370	$ 52,313,062
Total Operating Expenses	$ 503,691,090	$ 480,345,937	$ 484,653,874	$ 523,026,217	$ 548,490,219	$ 572,654,490	$ 598,145,757	$ 625,481,630	$ 654,449,084	$ 681,319,934	$ 707,897,022	$ 736,424,945
Total Operating Expenses	**$ 503,691,090**	**$ 480,345,937**	**$ 484,653,874**	**$ 523,026,217**	**$ 548,490,219**	**$ 572,654,490**	**$ 598,145,757**	**$ 625,481,630**	**$ 654,449,084**	**$ 681,319,934**	**$ 707,897,022**	**$ 736,424,945**
Operating Income (Loss)	**$ 34,980,612**	**$ 64,327,130**	**$ 128,406,279**	**$ 121,964,979**	**$ 141,061,528**	**$ 149,126,918**	**$ 157,806,107**	**$ 166,711,520**	**$ 176,195,368**	**$ 184,259,829**	**$ 195,019,084**	**$ 206,396,989**
NONOPERATING INCOME:												
Non-Operating Gain (Loss)	$ (716,072)	$ 6,517,579	$ 11,965,944	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total nonoperating income	$ (716,072)	$ 6,517,579	$ 11,965,944	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
System Overhead Allocation	$ 6,386,000	$ 58,617,000	$ 116,000,000	$ 121,660,800	$ 128,005,767	$ 134,150,612	$ 140,665,484	$ 147,575,178	$ 154,906,228	$ 161,566,927	$ 168,685,401	$ 176,293,768
NET INCOME (LOSS)	**$ 27,878,539**	**$ 12,227,708**	**$ 24,372,222**	**$ 304,179**	**$ 13,055,760**	**$ 14,976,306**	**$ 17,140,622**	**$ 19,136,342**	**$ 21,289,140**	**$ 22,692,903**	**$ 26,333,683**	**$ 30,103,220**

Source: Kadlec

Kadlec Regional Medical Center
Forecast Number of FTE Employees, Without Project, 2015-2026

	Actual	Actual	Actual	Projected	Forecasts							
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Total Paid FTEs	3,006	2,687	2,814	2,927	3,079	3,227	3,384	3,550	3,726	3,887	4,058	4,241
Total Paid Hours	6,251,456	5,588,198	5,853,044	6,087,349	6,404,822	6,712,282	7,038,256	7,383,985	7,750,798	8,084,068	8,440,244	8,820,932
Average Hourly Wage	$ 36.10	$ 41.70	$ 42.64	$ 44.13	$ 44.13	$ 44.13	$ 44.13	$ 44.13	$ 44.13	$ 44.13	$ 44.13	$ 44.13
Total Salaries	$ 225,667,161	$ 233,003,561	$ 249,581,338	$ 268,634,703	$ 282,644,790	$ 296,212,993	$ 310,598,242	$ 325,855,279	$ 342,042,700	$ 356,749,941	$ 372,467,981	$ 389,267,735
Employee Benefits	$ 44,996,247	$ 27,973,141	$ 20,949,812	$ 23,299,892	$ 24,515,050	$ 25,691,881	$ 26,939,578	$ 28,262,889	$ 29,666,897	$ 30,942,522	$ 32,305,818	$ 33,762,936
Benefits as % Sal & Wages	19.9%	12.0%	8.4%	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%

		Actual	Actual	Actual	Projected	Forecasts							
Labor Distribution		2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
FTEs	Management Physician FTEs	146	135	133	143	143	143	143	143	143	143	143	143
	RN FTEs	733	605	667	691	734	776	821	868	918	965	1,013	1,066
	Physician FTEs	140	138	153	156	164	172	180	189	198	207	216	226
	Non Physician Med Pract FTEs	35	67	88	92	97	102	106	112	117	122	128	133
	Other/Support FTEs	1,621	1,452	1,488	1,564	1,645	1,724	1,808	1,897	1,991	2,077	2,168	2,266
	Nonproductive FTEs	314	277	281	268	282	296	310	326	342	357	372	389
	Agency FTEs	16	14	4	13	14	14	15	16	17	17	18	19
	Total	3,006	2,687	2,814	2,927	3,079	3,227	3,384	3,550	3,726	3,887	4,058	4,241
Hours	Management Physician Hours	304,168	280,109	276,515	296,608	297,440	297,440	297,440	297,440	297,440	297,440	297,440	297,440
	RN Hours	1,525,639	1,257,601	1,386,445	1,437,176	1,526,704	1,614,573	1,707,473	1,805,874	1,910,155	2,006,905	2,107,350	2,217,105
	Physician Hours	290,793	287,027	318,989	324,126	341,034	357,410	374,751	393,153	412,686	430,442	449,309	469,606
	Non Physician Med Pract Hours	73,209	138,530	182,582	191,506	201,495	211,171	221,417	232,289	243,830	254,321	265,468	277,460
	Other/Support Hours	3,371,692	3,020,085	3,094,340	3,252,537	3,422,136	3,586,459	3,760,476	3,945,124	4,141,130	4,319,313	4,508,635	4,712,303
	Nonproductive Hours	652,473	575,469	585,354	558,438	587,569	615,782	645,660	677,364	711,017	741,611	774,117	809,086
	Agency Hours	33,482	29,377	8,819	26,957	28,363	29,725	31,167	32,698	34,322	35,799	37,368	39,056
	Total	6,251,456	5,588,198	5,853,044	6,087,348	6,404,742	6,712,559	7,038,384	7,383,940	7,750,580	8,085,830	8,439,687	8,822,056
Salaries & Wages	Management Physician	$ 17,682,112	$ 14,434,307	$ 14,762,610	$ 16,824,113	$ 16,871,305	$ 16,871,305	$ 16,871,305	$ 16,871,305	$ 16,871,305	$ 16,871,305	$ 16,871,305	$ 16,871,305
	RN	$ 48,776,745	$ 52,589,135	$ 59,224,823	$ 63,456,852	$ 67,409,877	$ 71,289,615	$ 75,391,502	$ 79,736,283	$ 84,340,710	$ 88,612,566	$ 93,047,626	$ 97,893,736
	Physician	$ 46,701,172	$ 51,341,069	$ 61,682,163	$ 66,923,038	$ 70,413,993	$ 73,795,100	$ 77,375,675	$ 81,175,004	$ 85,208,031	$ 88,874,325	$ 92,769,819	$ 96,960,500
	Non Physician Med Pract	$ 7,090,868	$ 9,259,945	$ 11,959,755	$ 13,380,900	$ 14,078,898	$ 14,754,932	$ 15,470,849	$ 16,230,504	$ 17,036,886	$ 17,769,942	$ 18,548,824	$ 19,386,728
	Other/Support	$ 75,364,601	$ 75,477,966	$ 76,781,415	$ 81,812,634	$ 86,078,618	$ 90,210,658	$ 94,587,724	$ 99,232,205	$ 104,162,370	$ 108,644,223	$ 113,406,261	$ 118,529,149
	Nonproductive	$ 24,959,052	$ 26,471,216	$ 24,421,394	$ 24,505,982	$ 25,784,305	$ 27,022,404	$ 28,333,545	$ 29,724,789	$ 31,201,609	$ 32,544,138	$ 33,970,596	$ 35,505,146
	Agency	$ 5,092,611	$ 3,429,923	$ 749,178	$ 1,731,183	$ 1,821,488	$ 1,908,952	$ 2,001,575	$ 2,099,857	$ 2,204,184	$ 2,299,025	$ 2,399,795	$ 2,508,200
	Total	$ 225,667,161	$ 233,003,561	$ 249,581,338	$ 268,634,702	$ 282,458,485	$ 295,852,966	$ 310,032,174	$ 325,069,947	$ 341,025,095	$ 355,615,523	$ 371,014,225	$ 387,654,765
Employee Benefits	Management Physician	$ 3,525,673	$ 1,732,904	$ 1,239,171	$ 1,459,231	$ 1,464,289	$ 1,465,105	$ 1,465,996	$ 1,466,859	$ 1,467,690	$ 1,467,992	$ 1,469,058	$ 1,469,413
	RN	$ 9,725,697	$ 6,313,566	$ 4,971,321	$ 5,503,897	$ 5,850,617	$ 6,190,792	$ 6,550,982	$ 6,932,593	$ 7,337,076	$ 7,710,283	$ 8,102,060	$ 8,526,091
	Physician	$ 9,311,844	$ 6,163,730	$ 5,177,590	$ 5,804,535	$ 6,111,350	$ 6,408,369	$ 6,723,393	$ 7,057,681	$ 7,412,527	$ 7,733,059	$ 8,077,870	$ 8,444,811
	Non Physician Med Pract	$ 1,413,863	$ 1,111,699	$ 1,003,900	$ 1,160,585	$ 1,221,931	$ 1,281,319	$ 1,344,306	$ 1,411,145	$ 1,482,095	$ 1,546,183	$ 1,615,127	$ 1,688,494
	Other/Support	$ 15,027,105	$ 9,061,474	$ 6,445,018	$ 7,095,977	$ 7,470,909	$ 7,833,896	$ 8,218,996	$ 8,627,647	$ 9,061,428	$ 9,453,261	$ 9,874,775	$ 10,323,340
	Nonproductive	$ 4,976,638	$ 3,177,990	$ 2,049,927	$ 2,125,514	$ 2,237,863	$ 2,346,626	$ 2,461,982	$ 2,584,393	$ 2,714,331	$ 2,831,703	$ 2,957,967	$ 3,092,334
	Agency	$ 1,015,426	$ 411,778	$ 62,886	$ 150,153	$ 158,090	$ 165,773	$ 173,923	$ 182,570	$ 191,749	$ 200,041	$ 208,961	$ 218,453
	Total	$ 44,996,247	$ 27,973,141	$ 20,949,812	$ 23,299,892	$ 24,515,050	$ 25,691,881	$ 26,939,578	$ 28,262,889	$ 29,666,897	$ 30,942,522	$ 32,305,818	$ 33,762,936

Source: Kadlec

Kadlec Regional Medical Center
Cost Center, Without Project, 2015-2026

	Actual	Actual	Actual	Projected	Forecasts							
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
ALL OTHER												
Total Patient Revenue												
Inpatient Revenue	$ 277,524,593	$ 287,991,510	$ 335,038,237	$ 350,239,362	$ 361,138,343	$ 368,361,109	$ 375,728,332	$ 383,242,898	$ 390,907,756	$ 390,907,756	$ 390,907,756	$ 390,907,756
Outpatient Revenue	$ 460,146,730	$ 461,873,711	$ 533,671,257	$ 565,691,533	$ 599,633,024	$ 635,611,006	$ 673,747,666	$ 714,172,526	$ 757,022,878	$ 802,444,251	$ 850,590,906	$ 901,626,360
Full Time Equivalents	2,266	2,048	2,130	2,243	2,371	2,510	2,659	2,816	2,983	3,136	3,299	3,474
Salaries & Wages	$ 187,886,104	$ 191,304,342	$ 204,595,890	$ 222,700,028	$ 235,026,194	$ 247,951,190	$ 261,662,256	$ 276,212,427	$ 291,658,494	$ 305,794,088	$ 320,906,181	$ 337,063,632
Employee Benefits	$ 42,398,073	$ 24,959,577	$ 17,649,468	$ 19,315,772	$ 20,384,875	$ 21,505,918	$ 22,695,140	$ 23,957,142	$ 25,296,849	$ 26,522,892	$ 27,833,632	$ 29,235,040
Professional Fees	$ 10,397,334	$ 8,180,635	$ 8,868,550	$ 6,406,457	$ 6,764,124	$ 7,118,609	$ 7,495,793	$ 7,897,265	$ 8,324,727	$ 8,730,034	$ 9,164,118	$ 9,629,063
Supplies	$ 59,032,025	$ 54,862,544	$ 59,903,932	$ 68,150,037	$ 72,187,337	$ 76,278,455	$ 80,641,194	$ 85,294,853	$ 90,260,143	$ 95,150,099	$ 100,389,608	$ 106,004,136
Purch Srv - Other	$ 32,589,168	$ 31,597,413	$ 26,155,128	$ 24,138,614	$ 25,456,678	$ 26,758,045	$ 28,140,424	$ 29,609,332	$ 31,170,673	$ 32,641,235	$ 34,213,547	$ 35,894,794
Depreciation	$ 19,123,814	$ 19,166,738	$ 16,010,001	$ 14,861,417	$ 17,706,217	$ 17,379,385	$ 16,906,401	$ 16,706,227	$ 16,460,249	$ 16,821,437	$ 15,067,326	$ 13,314,746
Taxes and Licenses	$ 8,869,257	$ 10,231,750	$ 5,892,624	$ 7,938,851	$ 7,933,036	$ 7,927,970	$ 7,922,674	$ 7,917,135	$ 7,911,339	$ 7,907,257	$ 7,902,929	$ 7,898,341
Other Direct Expenses	$ 40,305,428	$ 29,232,753	$ 31,407,290	$ 34,401,892	$ 36,215,926	$ 37,980,668	$ 39,852,639	$ 41,839,061	$ 43,947,667	$ 45,880,021	$ 47,945,567	$ 50,153,676
Recoveries	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Direct Expenses	**$ 400,601,202**	**$ 369,535,751**	**$ 370,482,883**	**$ 397,913,067**	**$ 421,674,388**	**$ 442,900,240**	**$ 465,316,522**	**$ 489,433,442**	**$ 515,030,143**	**$ 539,447,062**	**$ 563,422,906**	**$ 589,193,428**
Units of Measure (IP Days)	64,817	64,354	71,672	74,104	76,410	77,938	79,497	81,087	82,709	82,709	82,709	82,709
Ratios												
UOS / FTE	28.6	31.4	33.7	33.0	32.2	31.0	29.9	28.8	27.7	26.4	25.1	23.8
Total Revenue / UOS	11,381	11,652	12,121	12,360	12,574	12,882	13,201	13,534	13,879	14,428	15,011	15,628
Total Salaries / UOS	2,899	2,973	2,855	3,005	3,076	3,181	3,291	3,406	3,526	3,697	3,880	4,075
Total Supplies / UOS	911	853	836	920	945	979	1,014	1,052	1,091	1,150	1,214	1,282

Source: Kadlec

Kadlec Regional Medical Center
Cost Center, Without Project, 2015-2026

	Actual	Actual	Actual	Projected	Forecasts							
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
SURGERY												
Total Patient Revenue												
Inpatient Revenue	$ 106,331,942	$ 114,130,873	$ 123,824,843	$ 149,354,395	$ 154,002,104	$ 157,082,146	$ 160,223,789	$ 163,428,265	$ 166,696,830	$ 166,696,830	$ 166,696,830	$ 166,696,830
Outpatient Revenue	$ 75,705,531	$ 106,383,186	$ 118,895,026	$ 126,028,728	$ 133,590,451	$ 141,605,879	$ 150,102,231	$ 159,108,365	$ 168,654,867	$ 178,774,159	$ 189,500,609	$ 200,870,645
Full Time Equivalents	178	163	172	165	172	179	186	193	201	207	213	220
Salaries & Wages	$ 9,822,535	$ 11,567,501	$ 12,095,322	$ 12,152,864	$ 12,691,676	$ 13,181,327	$ 13,694,920	$ 14,233,784	$ 14,799,322	$ 15,245,894	$ 15,719,261	$ 16,221,029
Employee Benefits	$ 740,159	$ 815,019	$ 881,674	$ 1,054,072	$ 1,100,806	$ 1,143,276	$ 1,187,822	$ 1,234,560	$ 1,283,612	$ 1,322,345	$ 1,363,402	$ 1,406,923
Professional Fees	$ 4,209,796	$ 3,386,416	$ 4,517,834	$ 2,864,401	$ 2,991,398	$ 3,106,807	$ 3,227,860	$ 3,354,869	$ 3,488,165	$ 3,593,421	$ 3,704,992	$ 3,823,258
Supplies	$ 24,077,739	$ 27,200,246	$ 22,869,477	$ 26,316,934	$ 27,483,726	$ 28,544,062	$ 29,656,245	$ 30,823,149	$ 32,047,819	$ 33,014,867	$ 34,039,938	$ 35,126,513
Purch Srv - Other	$ 1,495,668	$ 1,190,405	$ 1,459,281	$ 1,067,538	$ 1,114,869	$ 1,157,881	$ 1,202,997	$ 1,250,332	$ 1,300,010	$ 1,339,238	$ 1,380,820	$ 1,424,896
Depreciation	$ 3,175,534	$ 2,166,336	$ 1,224,422	$ 1,137,461	$ 1,187,892	$ 1,233,721	$ 1,281,792	$ 1,332,227	$ 1,385,159	$ 1,426,957	$ 1,471,262	$ 1,518,226
Taxes and Licenses	$ 1,636	$ 25,391	$ 2,050	$ 26,598	$ 27,777	$ 28,849	$ 29,973	$ 31,152	$ 32,390	$ 33,367	$ 34,403	$ 35,502
Other Direct Expenses	$ 334,850	$ 275,078	$ 313,300	$ 358,930	$ 374,844	$ 389,306	$ 404,475	$ 420,390	$ 437,093	$ 450,282	$ 464,263	$ 479,082
Recoveries	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Direct Expenses	**$ 43,857,918**	**$ 46,626,391**	**$ 43,363,361**	**$ 44,978,799**	**$ 46,972,987**	**$ 48,785,229**	**$ 50,686,083**	**$ 52,680,463**	**$ 54,773,570**	**$ 56,426,371**	**$ 58,178,341**	**$ 60,035,428**
Units of Measure (Minutes)	1,068,711	1,074,811	1,137,613	1,065,853	1,108,487	1,151,253	1,196,110	1,243,174	1,292,568	1,331,572	1,372,915	1,416,740
Ratios												
UOS / FTE	6,008	6,594	6,607	6,473	6,446	6,446	6,446	6,446	6,446	6,446	6,446	6,446
Total Revenue / UOS	170	205	213	258	259	259	259	259	259	259	259	259
Total Salaries / UOS	9	11	11	11	11	11	11	11	11	11	11	11
Total Supplies / UOS	23	25	20	25	25	25	25	25	25	25	25	25

Source: Kadlec

Kadlec Regional Medical Center
Cost Center, Without Project, 2015-2026

	Actual	Actual	Actual	Projected	Forecasts							
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
ACUTE												
Total Patient Revenue												
Inpatient Revenue	$ 137,418,561	$ 147,075,451	$ 170,824,464	$ 189,991,535	$ 195,903,817	$ 199,821,894	$ 203,818,331	$ 207,894,698	$ 212,052,592	$ 212,052,592	$ 212,052,592	$ 212,052,592
Outpatient Revenue	$ 11,165,631	$ 12,665,282	$ 14,122,194	$ 14,969,526	$ 15,867,697	$ 16,819,759	$ 17,828,945	$ 18,898,681	$ 20,032,602	$ 21,234,558	$ 22,508,632	$ 23,859,150
Full Time Equivalents	435	359	381	387	400	400	400	400	400	400	400	400
Salaries & Wages	$ 18,827,534	$ 19,804,002	$ 21,380,186	$ 21,870,904	$ 22,597,631	$ 22,597,631	$ 22,597,631	$ 22,597,631	$ 22,597,631	$ 22,597,631	$ 22,597,631	$ 22,597,631
Employee Benefits	$ 1,210,336	$ 1,477,498	$ 1,609,119	$ 1,896,962	$ 1,959,994	$ 1,959,994	$ 1,959,994	$ 1,959,994	$ 1,959,994	$ 1,959,994	$ 1,959,994	$ 1,959,994
Professional Fees	$ 50,976	$ 53,445	$ 41,870	$ 61,380	$ 63,420	$ 64,878	$ 66,377	$ 67,918	$ 69,503	$ 69,863	$ 70,244	$ 70,649
Supplies	$ 2,311,337	$ 2,646,831	$ 2,646,917	$ 2,963,059	$ 3,061,516	$ 3,131,922	$ 3,204,287	$ 3,278,682	$ 3,355,184	$ 3,372,561	$ 3,390,980	$ 3,410,504
Purch Srv - Other	$ 818,419	$ 976,555	$ 1,387,653	$ 1,464,830	$ 1,513,503	$ 1,548,310	$ 1,584,084	$ 1,620,863	$ 1,658,683	$ 1,667,273	$ 1,676,378	$ 1,686,030
Depreciation	$ 615,390	$ 549,661	$ 809,059	$ 955,275	$ 987,017	$ 1,009,716	$ 1,033,046	$ 1,057,031	$ 1,081,695	$ 1,087,297	$ 1,093,235	$ 1,099,529
Taxes and Licenses	$ 9,469	$ 8,756	$ 6,430	$ 9,882	$ 10,211	$ 10,445	$ 10,687	$ 10,935	$ 11,190	$ 11,248	$ 11,309	$ 11,375
Other Direct Expenses	$ 169,503	$ 825,471	$ 256,559	$ 257,438	$ 265,993	$ 272,110	$ 278,397	$ 284,861	$ 291,507	$ 293,017	$ 294,617	$ 296,314
Recoveries	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Direct Expenses	**$ 24,012,964**	**$ 26,342,219**	**$ 28,137,794**	**$ 29,479,730**	**$ 30,459,284**	**$ 30,595,005**	**$ 30,734,502**	**$ 30,877,914**	**$ 31,025,386**	**$ 31,058,883**	**$ 31,094,389**	**$ 31,132,025**
Units of Measure (IP Days)	50,020	49,367	54,027	56,994	59,274	59,274	59,274	59,274	59,274	59,274	59,274	59,274
Ratios												
UOS / FTE	115	137	142	147	148	148	148	148	148	148	148	148
Total Revenue / UOS	2,970	3,236	3,423	3,596	3,573	3,655	3,739	3,826	3,915	3,936	3,957	3,980
Total Salaries / UOS	376	401	396	384	381	381	381	381	381	381	381	381
Total Supplies / UOS	46	54	49	52	52	53	54	55	57	57	57	58

Source: Kadlec

Kadlec Regional Medical Center
Cost Center, Without Project, 2015-2026

	Actual	Actual	Actual	Projected	Forecasts							
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
ICU												
Total Patient Revenue												
Inpatient Revenue	$ 31,435,026	$ 33,687,766	$ 46,227,288	$ 49,476,715	$ 51,016,364	$ 52,036,691	$ 53,077,425	$ 54,138,973	$ 55,221,753	$ 55,221,753	$ 55,221,753	$ 55,221,753
Outpatient Revenue	$ 38,949	$ 101,717	$ 581,682	$ 616,582	$ 653,577	$ 692,792	$ 734,360	$ 778,421	$ 825,126	$ 874,634	$ 927,112	$ 982,739
Full Time Equivalents	80	71	90	92	95	95	95	95	95	95	95	95
Salaries & Wages	$ 5,098,313	$ 5,859,628	$ 7,363,510	$ 7,711,180	$ 7,953,883	$ 7,953,883	$ 7,953,883	$ 7,953,883	$ 7,953,883	$ 7,953,883	$ 7,953,883	$ 7,953,883
Employee Benefits	$ 385,686	$ 432,512	$ 543,379	$ 668,825	$ 689,876	$ 689,876	$ 689,876	$ 689,876	$ 689,876	$ 689,876	$ 689,876	$ 689,876
Professional Fees	$ 14,585	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Supplies	$ 818,213	$ 1,101,115	$ 1,256,195	$ 1,342,624	$ 1,384,882	$ 1,413,281	$ 1,442,289	$ 1,471,922	$ 1,502,195	$ 1,503,522	$ 1,504,928	$ 1,506,419
Purch Srv - Other	$ 350,124	$ 469,298	$ 576,824	$ 621,218	$ 640,771	$ 653,910	$ 667,332	$ 681,043	$ 695,050	$ 695,664	$ 696,315	$ 697,005
Depreciation	$ 325,988	$ 279,465	$ 458,728	$ 481,524	$ 496,679	$ 506,864	$ 517,268	$ 527,895	$ 538,753	$ 539,228	$ 539,733	$ 540,268
Taxes and Licenses	$ 540	$ 720	$ 1,090	$ 884	$ 912	$ 930	$ 950	$ 969	$ 989	$ 990	$ 991	$ 992
Other Direct Expenses	$ 95,424	$ 918,758	$ 208,337	$ 98,216	$ 101,307	$ 103,385	$ 105,507	$ 107,674	$ 109,889	$ 109,986	$ 110,089	$ 110,198
Recoveries	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Direct Expenses	**$ 7,088,873**	**$ 9,061,496**	**$ 10,408,063**	**$ 10,924,471**	**$ 11,268,309**	**$ 11,322,128**	**$ 11,377,103**	**$ 11,433,262**	**$ 11,490,634**	**$ 11,493,149**	**$ 11,495,814**	**$ 11,498,640**
Units of Measure (IP Days)	6,010	5,941	8,064	8,160	8,486	8,486	8,486	8,486	8,486	8,486	8,486	8,486
Ratios												
UOS / FTE	75	83	89	89	90	90	90	90	90	90	90	90
Total Revenue / UOS	5,237	5,688	5,805	6,139	6,089	6,213	6,341	6,471	6,604	6,610	6,616	6,623
Total Salaries / UOS	848	986	913	945	937	937	937	937	937	937	937	937
Total Supplies / UOS	136	185	156	165	163	167	170	173	177	177	177	178

Source: Kadlec

Kadlec Regional Medical Center
Cost Center, Without Project, 2015-2026

	Actual	Actual	Actual	Projected	Forecasts							
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
PHARMACY												
Total Patient Revenue												
Inpatient Revenue	$ 42,435,305	$ 43,296,014	$ 46,165,934	$ 54,658,915	$ 56,359,827	$ 57,487,024	$ 58,636,764	$ 59,809,500	$ 61,005,690	$ 61,005,690	$ 61,005,690	$ 61,005,690
Outpatient Revenue	$ 27,063,053	$ 27,293,020	$ 30,402,928	$ 32,227,103	$ 34,160,730	$ 36,210,373	$ 38,382,996	$ 40,685,976	$ 43,127,134	$ 45,714,762	$ 48,457,648	$ 51,365,107
Full Time Equivalents	47	45	40	40	42	43	45	46	48	49	51	52
Salaries & Wages	$ 4,032,674	$ 4,468,088	$ 4,146,431	$ 4,199,727	$ 4,375,406	$ 4,528,962	$ 4,689,552	$ 4,857,555	$ 5,033,370	$ 5,158,445	$ 5,291,026	$ 5,431,561
Employee Benefits	$ 261,993	$ 288,535	$ 266,171	$ 364,261	$ 379,499	$ 392,817	$ 406,746	$ 421,317	$ 436,567	$ 447,415	$ 458,914	$ 471,104
Professional Fees	$ -	$ 58,735	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Supplies	$ 13,028,732	$ 12,442,865	$ 14,836,423	$ 18,748,966	$ 19,533,256	$ 20,218,780	$ 20,935,707	$ 21,685,724	$ 22,470,621	$ 23,029,000	$ 23,620,882	$ 24,248,277
Purch Srv - Other	$ 296,975	$ 277,540	$ 278,034	$ 993,255	$ 1,034,804	$ 1,071,121	$ 1,109,101	$ 1,148,834	$ 1,190,415	$ 1,219,996	$ 1,251,352	$ 1,284,589
Depreciation	$ -	$ -	$ 15	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Taxes and Licenses	$ 48,223	$ 90,470	$ 94,656	$ 102,300	$ 106,579	$ 110,320	$ 114,232	$ 118,324	$ 122,606	$ 125,653	$ 128,883	$ 132,306
Other Direct Expenses	$ 890,567	$ 626,270	$ 895,125	$ 984,907	$ 1,026,107	$ 1,062,118	$ 1,099,779	$ 1,139,179	$ 1,180,410	$ 1,209,743	$ 1,240,835	$ 1,273,793
Recoveries												
Total Direct Expenses	**$ 18,559,164**	**$ 18,252,505**	**$ 20,516,855**	**$ 25,393,416**	**$ 26,455,651**	**$ 27,384,118**	**$ 28,355,116**	**$ 29,370,933**	**$ 30,433,989**	**$ 31,190,253**	**$ 31,991,892**	**$ 32,841,629**
Units of Measure (Adj Discharg	37,608	35,452	38,591	37,383	38,878	40,243	41,670	43,163	44,725	45,836	47,014	48,263
Ratios												
UOS / FTE	809	786	953	932	930	930	930	930	930	930	930	930
Total Revenue / UOS	1,848	1,991	1,984	2,324	2,328	2,328	2,328	2,328	2,328	2,328	2,328	2,328
Total Salaries / UOS	107	126	107	112	113	113	113	113	113	113	113	113
Total Supplies / UOS	346	351	384	502	502	502	502	502	502	502	502	502

Source: Kadlec

Kadlec Regional Medical Center
Deductions Summary, Without Project, 2015-2026

	Actual	Actual	Actual	Projected	Forecasts							
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Contractual Allowances												
Medicare	$ 363,207,350	$ 383,188,062	$ 514,273,983	$ 566,598,825	$ 596,148,615	$ 624,766,392	$ 655,107,464	$ 687,287,296	$ 721,429,472	$ 752,449,686	$ 785,601,853	$ 821,035,552
Medicaid	$ 41,076,979	$ 50,848,161	$ 52,758,583	$ 54,615,105	$ 57,463,442	$ 60,221,942	$ 63,146,553	$ 66,248,403	$ 69,539,407	$ 72,529,480	$ 75,725,055	$ 79,140,550
Other	$ 476,870,703	$ 533,334,511	$ 581,448,118	$ 626,435,908	$ 659,106,377	$ 690,746,406	$ 724,291,723	$ 759,869,986	$ 797,617,833	$ 831,914,013	$ 868,567,298	$ 907,743,060
Total Contractual Allowances	$ 881,155,032	$ 967,370,734	$ 1,148,480,684	$ 1,247,649,837	$ 1,312,718,435	$ 1,375,734,740	$ 1,442,545,740	$ 1,513,405,685	$ 1,588,586,712	$ 1,656,893,179	$ 1,729,894,207	$ 1,807,919,162
Inpatient	$ 5,783,069	$ 6,187,440	$ 9,328,386	$ 10,704,659	$ 10,721,308	$ 10,935,734	$ 11,154,449	$ 11,377,538	$ 11,605,089	$ 11,605,089	$ 11,605,089	$ 11,605,089
Outpatient	$ 8,764,086	$ 12,623,457	$ 17,837,337	$ 22,794,959	$ 15,803,046	$ 16,861,906	$ 17,993,152	$ 19,201,836	$ 20,493,368	$ 21,873,546	$ 23,348,580	$ 24,925,127
Total Charity Care	$ 14,547,155	$ 18,810,896	$ 27,165,723	$ 33,499,619	$ 26,524,354	$ 27,797,640	$ 29,147,601	$ 30,579,374	$ 32,098,457	$ 33,478,634	$ 34,953,669	$ 36,530,215
Total Bad Debt	$ 10,707,404	$ 11,759,853	$ 10,828,964	$ 13,427,496	$ 14,127,780	$ 14,805,976	$ 15,525,011	$ 16,287,622	$ 17,096,738	$ 17,831,868	$ 18,617,522	$ 19,457,245
Total Deductions From Revenue	$ 906,409,592	$ 997,941,483	$ 1,186,475,371	$ 1,294,576,953	$ 1,353,370,568	$ 1,418,338,356	$ 1,487,218,353	$ 1,560,272,681	$ 1,637,781,906	$ 1,708,203,681	$ 1,783,465,397	$ 1,863,906,622

Source: Kadlec

Kadlec Regional Medical Center
Selected Utilization and Financial Forecasts, Without Project, 2015-2026

Volume Indicators

	Actual	Actual	Actual	Projected	Forecasts							
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Admissions	14,962	14,489	15,635	16,166	16,669	17,002	17,342	17,689	18,043	18,043	18,043	18,043
Patient Days*	64,817	64,354	71,672	74,104	76,410	77,938	79,497	81,087	82,709	82,709	82,709	82,709
ALOS	4.33	4.44	4.58	4.58	4.58	4.58	4.58	4.58	4.58	4.58	4.58	4.58
Inpatient ED Visits	9,225	8,610	9,548	10,443	10,768	10,983	11,203	11,427	11,656	11,656	11,656	11,656
Outpatient ED Visits	89,032	87,119	91,072	96,536	102,328	108,468	114,976	121,875	129,187	136,939	145,155	153,864
Total ED Visits	98,257	95,729	100,620	106,979	113,096	119,452	126,179	133,302	140,843	148,594	156,811	165,520

Depreciation and Interest per Patient Day

	Actual	Actual	Actual	Projected	Forecasts							
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Total Depreciation	$ 23,240,726	$ 22,162,200	$ 18,502,224	$ 19,661,977	$ 20,377,806	$ 20,129,687	$ 19,738,506	$ 19,623,380	$ 19,465,856	$ 19,874,919	$ 18,171,555	$ 16,472,768
Total Interest	$ 9,766,708	$ 10,563,718	$ 11,129,833	$ 11,489,426	$ 11,489,426	$ 11,489,426	$ 11,489,426	$ 11,489,426	$ 11,489,426	$ 11,489,426	$ 11,489,426	$ 11,489,426
Total Depreciation & Interest	$ 33,007,434	$ 32,725,919	$ 29,632,058	$ 31,151,402	$ 31,867,231	$ 31,619,112	$ 31,227,932	$ 31,112,806	$ 30,955,281	$ 31,364,344	$ 29,660,981	$ 27,962,194
Patient Days	$ 64,817	$ 64,354	$ 71,672	$ 74,104	$ 76,410	$ 77,938	$ 79,497	$ 81,087	$ 82,709	$ 82,709	$ 82,709	$ 82,709
Total Depreciation & Interest / Patient Day	$ 509	$ 509	$ 413	$ 420	$ 417	$ 406	$ 393	$ 384	$ 374	$ 379	$ 359	$ 338

Projected Capital Expenditures

	Actual	Actual	Actual	Projected	Forecasts							
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Project Capital Expenditure												
Routine Capital				$ 15,000,000	$ 15,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 5,000,000
Cost of Securing Sources of Financing												
Total Estimated Capital Expenditure				$ 15,000,000	$ 15,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 5,000,000

Source: Kadlec

*Patient days excludes normal newborns (DRG 795) and the rehabilitation unit. Consequently the proforma patient days will not match Table 4 in the application, which has different exclusions.

Exhibit 11
Proposed Equipment List

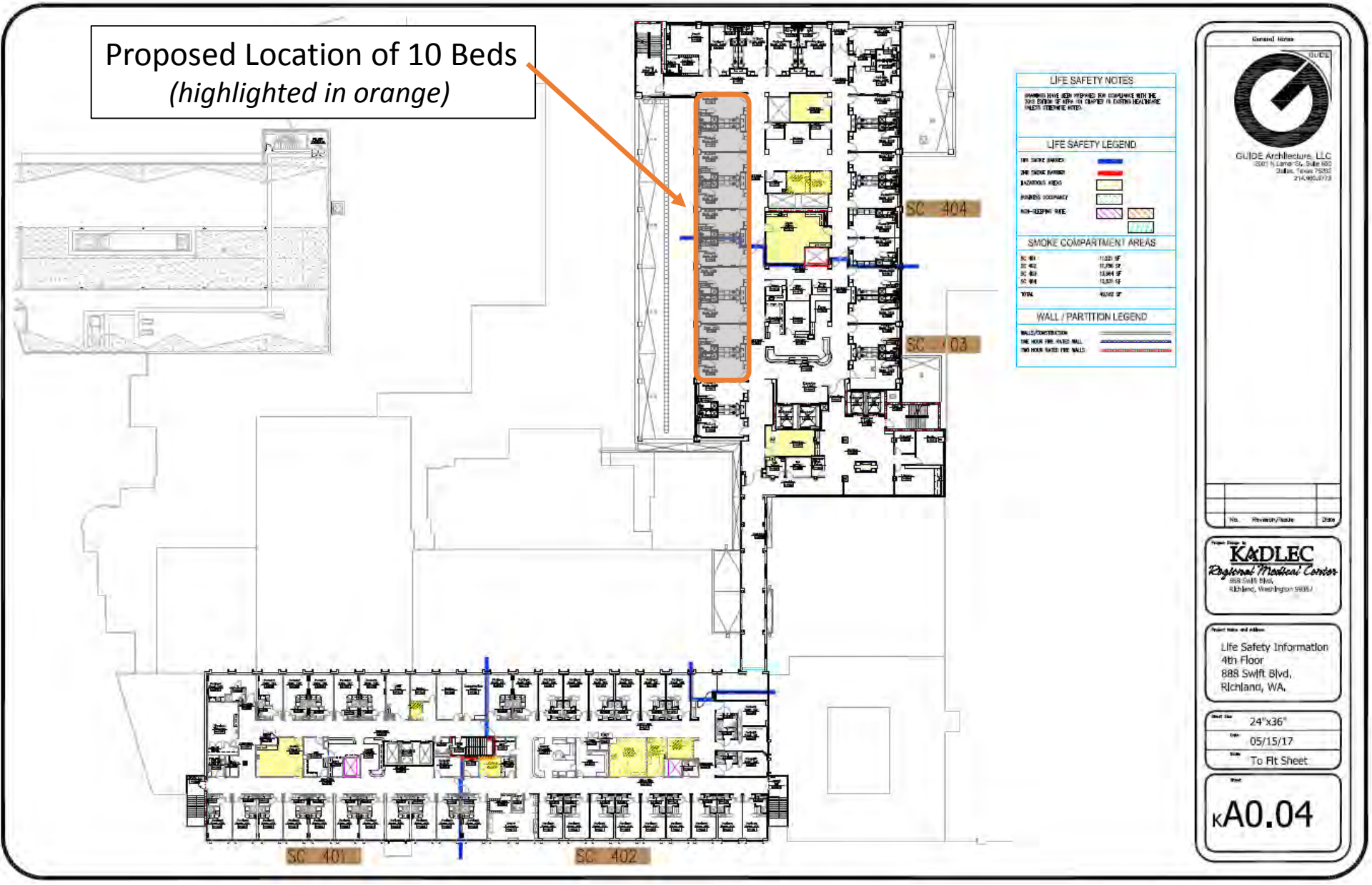
Kadlec Regional Medical Center
Equipment list for 67 additional beds

Description	Qty	Cost/unit	Total Cost*
Monitors	34	12,500	425,000
Monitor Central Station	3	35,000	105,000
Code Cart	2	12,500	25,000
Acute Care Beds	34	11,500	391,000
Stretchers	16	9,700	155,200
Pyxis (IT)	2	25,000	50,000
3OP Semi-Private Modications	9	5,000	45,000
EPIC (IT)	1	57,000	57,000

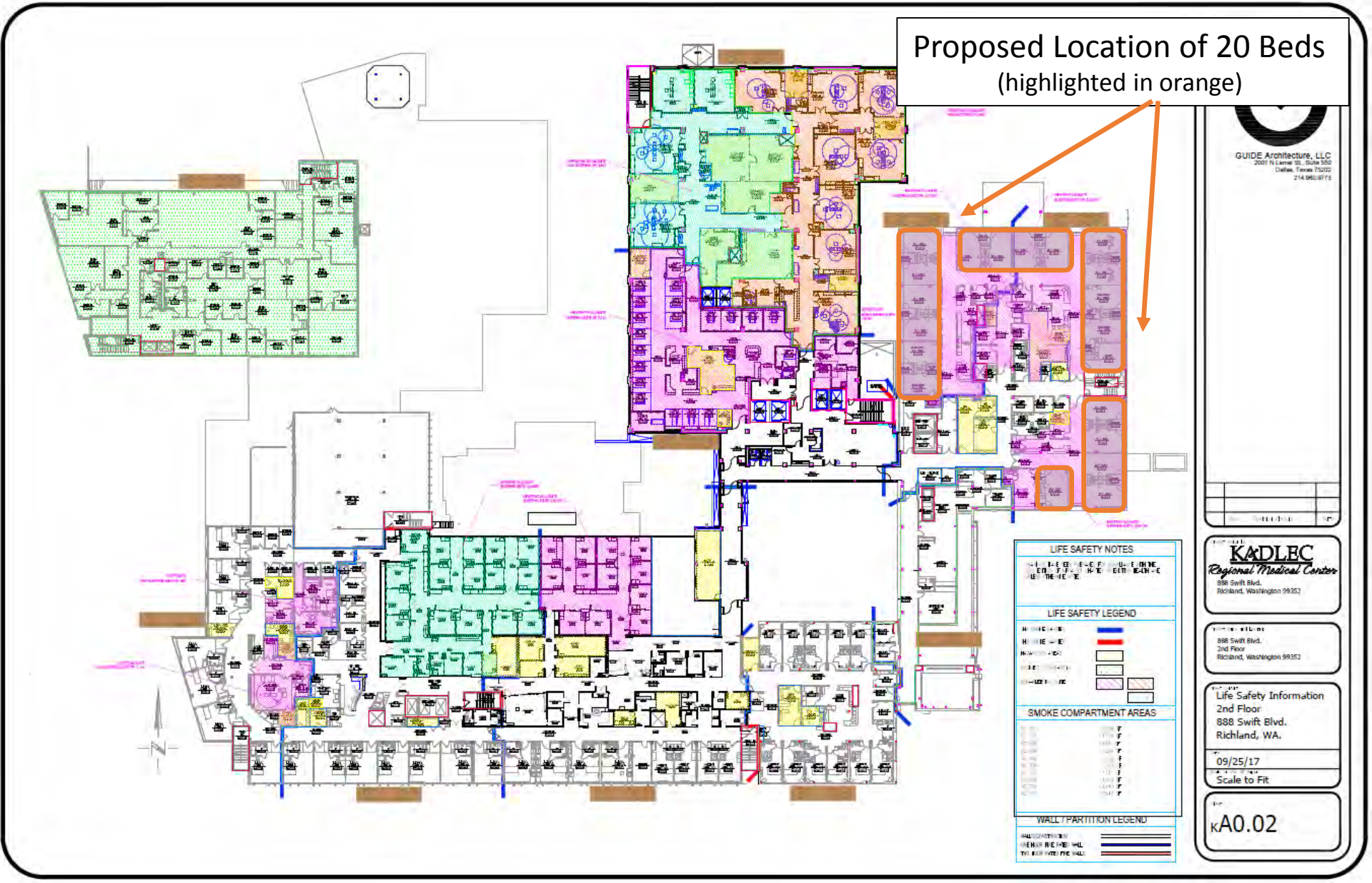
*Includes Sales Tax

Exhibit 12
Single Line Drawings – Current Locations

Kadlec 4th Floor – Without the Project



Kadlec 2nd Floor – Without the Project



Kadlec 3rd Floor – Without the Project

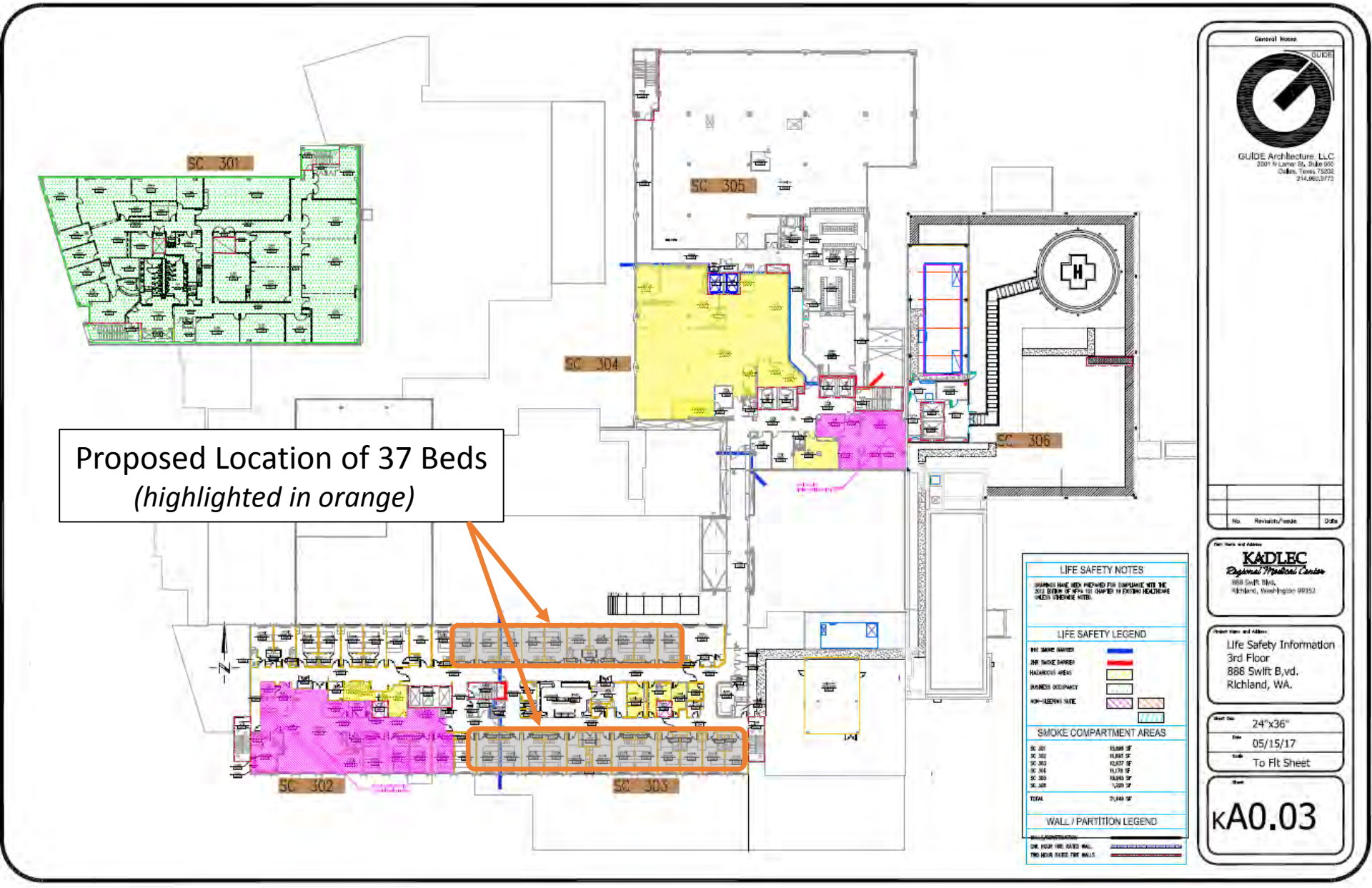


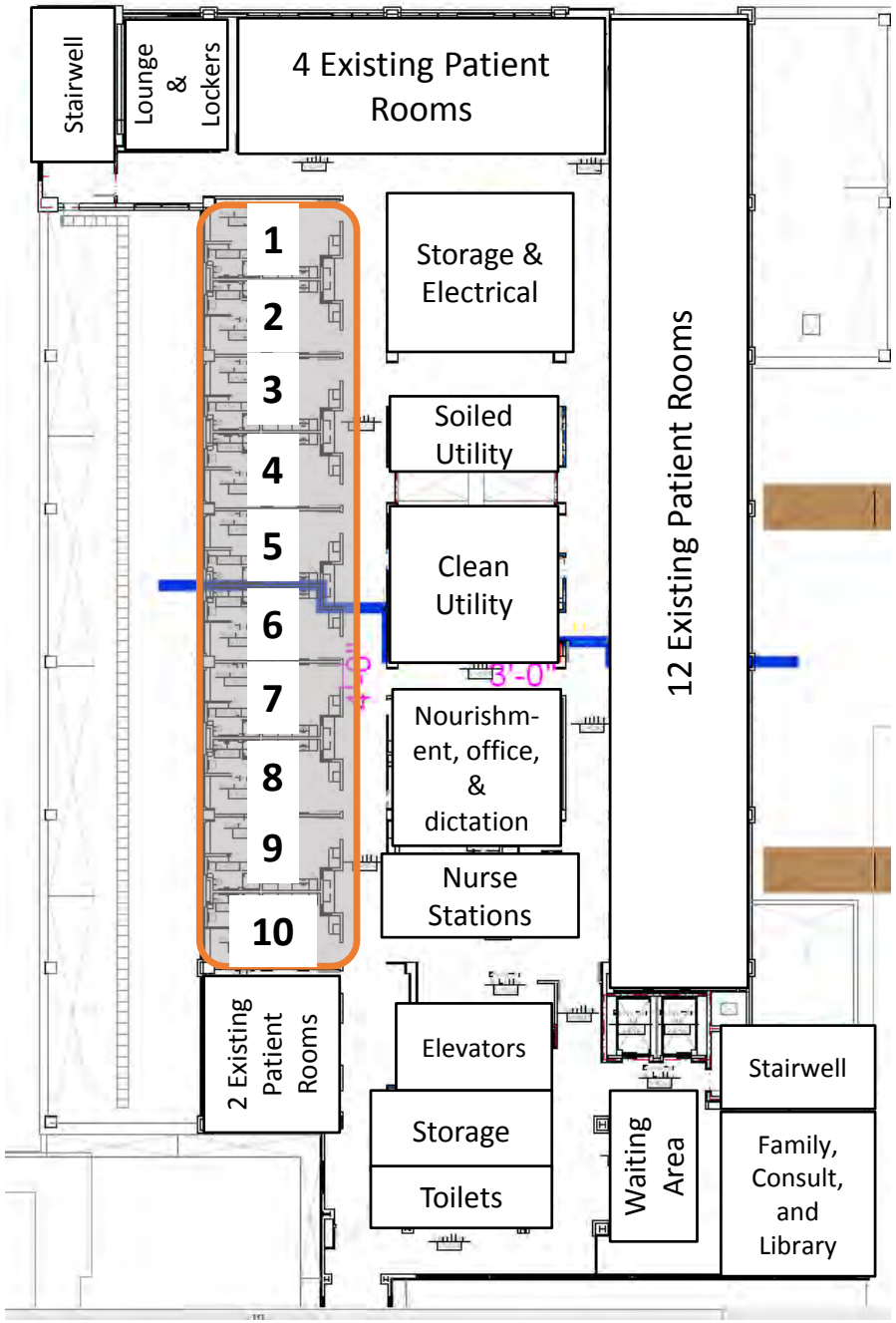
Exhibit 13
Single Line Drawings – Proposed Locations

Kadlec 4th Floor – With the Project (10 bed addition - Phase 1)

Proposed Location of 10 Beds

All other operational areas on the 4th floor remain the same before and after the project

No construction required in Phase 1

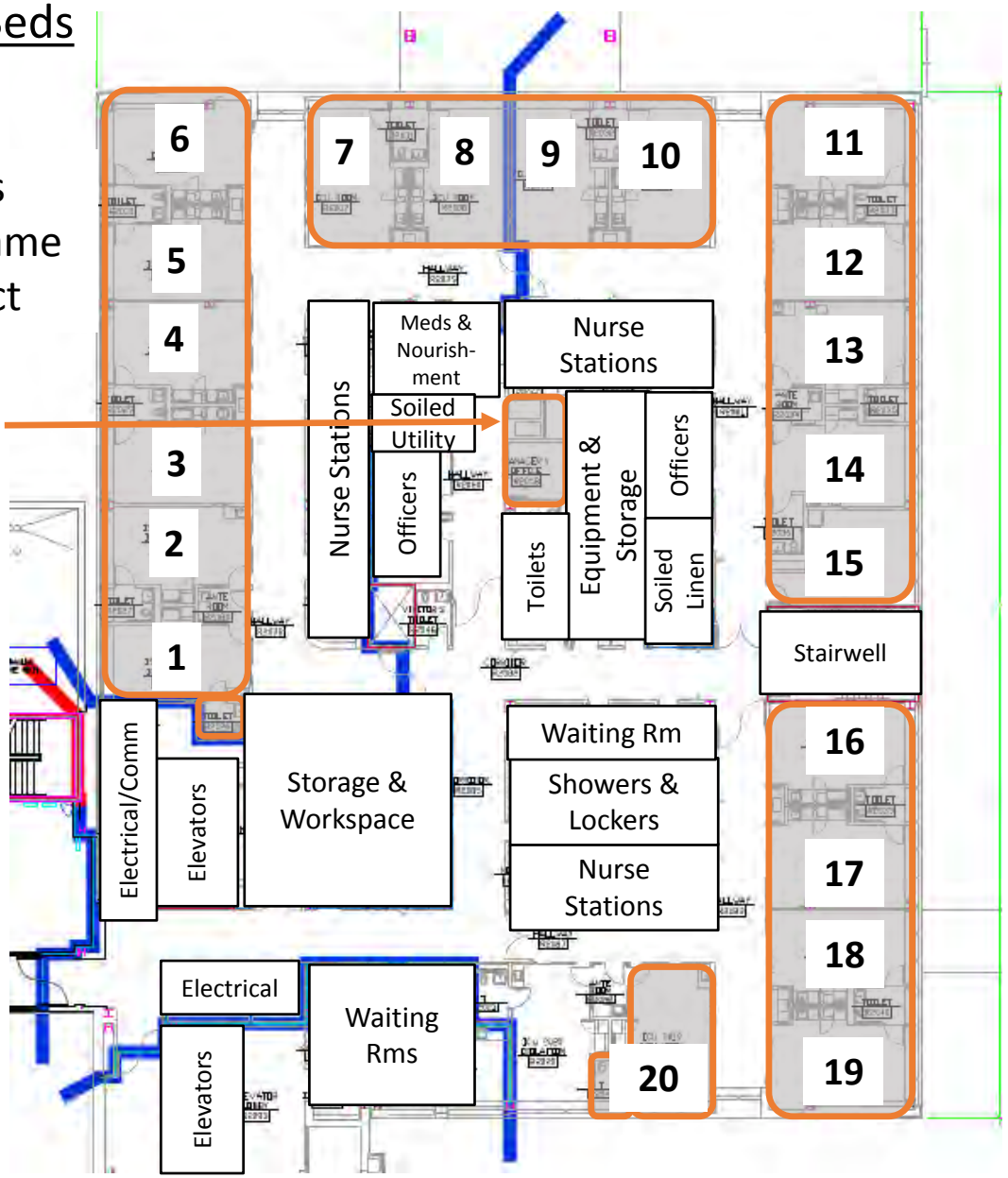


Kadlec 2nd Floor – With the Project (20 bed addition – Phase 2)

Proposed Location of 20 Beds

All other operational areas on the 2nd floor remain the same before and after the project

Location of 2 new showers



Kadlec 3rd Floor – With the Project (37 bed addition – Phase 3)

Proposed Location of 37 Beds

(9 single occupancy and 14 double occupancy rooms)

All other operational areas on
the 3rd floor remain the same before and after the project

No construction required in Phase 3

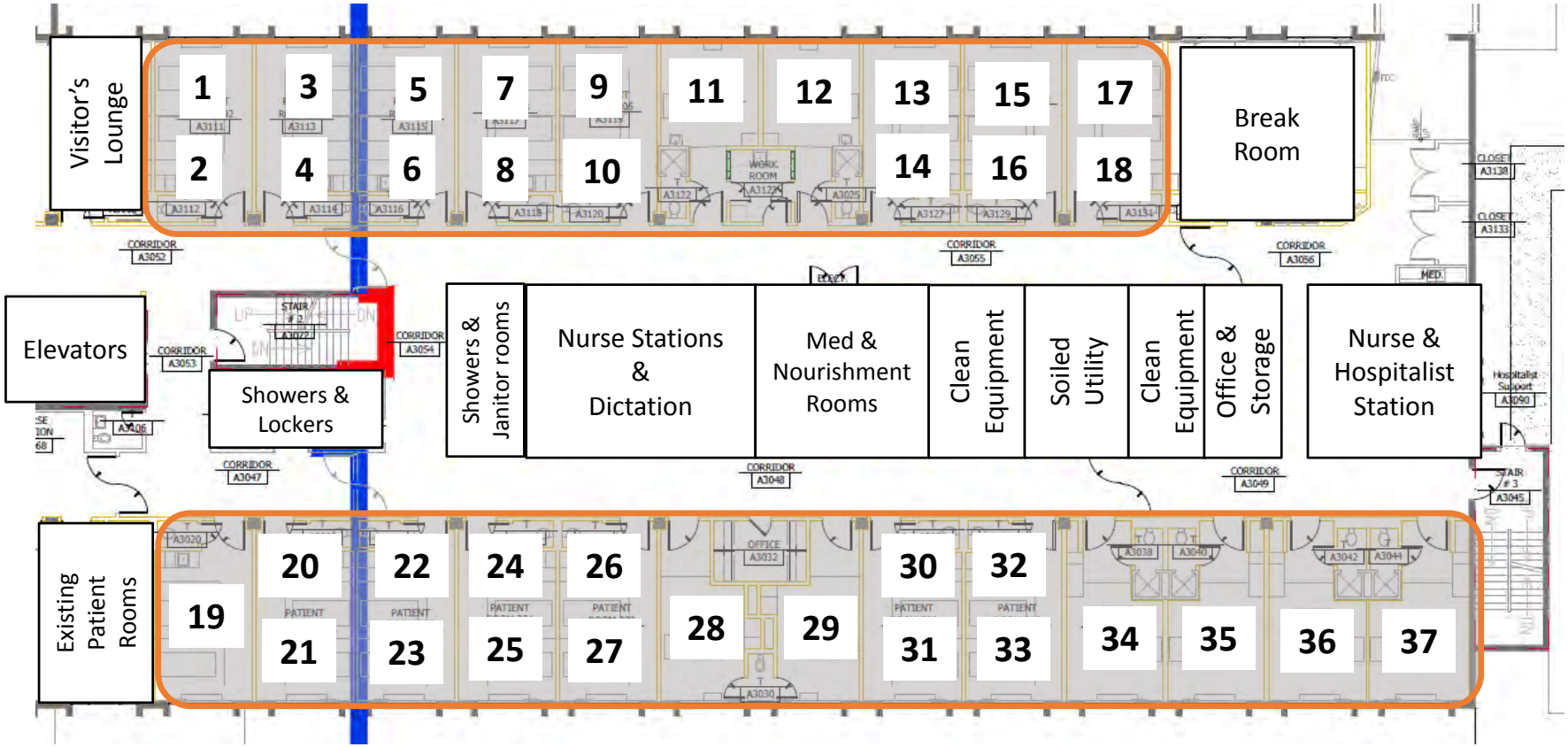


Exhibit 14
Purchase and Sale Agreement

REAL ESTATE PURCHASE AND SALE AGREEMENT
(Please read carefully before signing.)

THIS AGREEMENT is made on the 9th day of October 2009, by and between **KADLEC REGIONAL MEDICAL CENTER**, a Washington Non-Profit Corporation, and/or assigns, hereinafter "Buyer" and **JOAN H. MOORE, TRUSTEE OF THE JOHN M. MOORE NON-EXEMPT MARITAL TRUST,** and **WASHINGTON TRUST BANK, SUCCESSOR TRUSTEE UNDER THE WILL OF FRANCES PAULSEN MOORE** collectively hereinafter "Seller".

WHEREAS, Joan H. Moore, Trustee of the John M. Moore Non-Exempt Marital Trust Established pursuant to the Fourth Amendment and Restatement of Declaration of Trust – The John M. Moore Living trust dated December 30, 1992 owns an undivided 60% interest in the subject real property and Washington Trust Bank, Successor Trustee under the Will of Frances Paulsen Moore owns an undivided 40% interest in the subject real property, and hereby agree as follows:

The selling agent shall receive from Kadlec Regional Medical Center, and/or assigns, the sum of $10,000.00 in the form of a check, which will be deposited with the Cascade Title Company by Broker within 10 days after mutual acceptance. The earnest money will be applied as a credit to Buyer on the closing of the following described real estate, which Buyer and/or assigns agrees to buy and Seller agrees to sell, located in Benton County, Washington, commonly known as 1268 Lee Blvd., Richland, WA 99352 and 1270 Lee Blvd., Richland, WA 99352 and more accurately described in Exhibit "A"- Legal Description attached hereto and incorporated herein by reference and referred to as the "Property".

1. AGENCY DISCLOSURE: At the signing of this Agreement the selling agent, James A. Quigley of Kiemle & Hagood, represented the Seller and the Buyer represented itself. Each party signing this document confirms that prior oral and/or written disclosure of agency was provided him/her in this transaction. Seller shall be responsible to pay all commissions or other amounts due to its agent as a result of this transaction and agrees to hold Buyer harmless and to indemnify Buyer from any claims from such agent.

2. PURCHASE PRICE: The total price is One Million Eight Hundred Fifty Thousand and no/100ths Dollars ($1,850,000.00), payable as follows:
   a.) The sum of $250,000.00 paid in cash at time of Closing; and
   b.) The remaining sum of $1,600,000.00 paid by a Promissory Note calling for interest at a rate of 5 ½ % on the unpaid balance due in full no later than January 6, 2010 and secured by a Deed of Trust on the Property.

3. CONTINGENCIES:

   a.) Structural/Environmental Inspection: This transaction is contingent upon Buyer conducting a structural and environmental inspection of the premises, performed at the Buyer's cost showing the property to be in a condition satisfactory to Buyer and to be satisfactory for Buyer's purpose, in Buyer's sole discretion. Buyer must either waive or satisfy this contingency within 45 days following the execution of this purchase and sale agreement. The parties agree to terminate this Agreement and to refund all earnest money in the event the Buyer notifies Seller in writing of its election not to purchase the property, which shall be in the sole discretion of the Buyer. Seller grants Buyer the right to enter on to the Property to conduct studies, test and inspections, including a Phase II Environmental Assessment. Buyer agrees to repair all damages to the Property caused by

its actions or those of their agents or consultants.

b.) Board Approval: This Agreement is contingent upon final approval of the purchase by the Boards of Directors for Kadlec Health System and Kadlec Regional Medical Center. This contingency must be satisfied within 30 days following the execution of this purchase and sale agreement. The time for satisfaction of this contingency may only be extended by written agreement of both Buyer and Seller. The parties agree to terminate this Agreement and to refund all Earnest Money in the event that 90 days expire hereunder without extension or if the Buyer notifies Seller in writing of the sole shareholder's failure to approve the purchase.

c.) Termination of Leases: This transaction is further contingent upon Seller terminating all existing leases over the premises by or before the date of closing. This contingency must be either waived by Buyer or satisfied by Seller by or before the closing date set forth in Section 10. Buyer's election to waive this contingency must be in writing and signed by Buyer.

In the event any of these contingencies are not fulfilled as outlined herein, this transaction shall be null and void and the Earnest Money shall be refunded in full, unless such contingencies are either waived by written notice from the party requiring the contingency or the contingency is modified and approved by written agreement of both Buyer and Seller. If the Buyer fails to give written notice to the Seller of Buyer's approval of any of the contingencies and/or waiver of the contingencies by the end of the stated time period, this Agreement shall terminate and be unenforceable and the Earnest Money shall be returned in full to the Buyer.

4. TITLE: Title to the property shall be marketable at closing as set forth below and shall free and clear of all liens and judgments. Rights, reservations, covenants, conditions and restrictions presently of record or of apparent use, easements and encroachments of record or apparent use, not materially affecting the value of the property or unduly interfering with Buyer's intended use of the property shall not cause the title to be considered unmarketable. Buyer shall conclusively be deemed to have accepted the condition of title unless Seller receives notice of Buyer's objections within fourteen (14) days after preliminary commitment for title insurance is received by and made available to Buyer. Encumbrances to be discharged by Seller shall be paid by Seller on or before closing and may be paid out of the closing.

5. TITLE INSURANCE: The parties authorize the closing agent, at Seller's expense, to apply for a standard form owner's policy of title insurance to be issued by Cascade Title Company. The title insurance shall contain no exceptions other than those contained in said standard form, those referred to in this Agreement, those accepted by Buyer, and those not inconsistent with this Agreement. If title is not so insurable and cannot be made so insurable prior to closing, Buyer may elect either to waive such encumbrances or defects and proceed with the closing, or to terminate this Agreement and receive a refund of the earnest money, at which time, this Agreement shall be at an end. Buyer acknowledges that a standard form title insurance does not insure the location of boundaries, and that an extended form of insurance is available at additional cost, with such additional cost to be borne by the Buyer. If Buyer elects to purchase extended coverage, Buyer shall advise the title insurance company of such election in a timely manner.

6. CONVEYANCE: This Agreement provides for conveying fee title and title shall be conveyed by statutory warranty deed free of encumbrances and defects except those accepted in this Agreement or otherwise

acceptable to Buyer.

7. PERSONAL PROPERTY: This purchase includes all personal property at nominal value.

8. SELLER'S REPRESENTATIONS: Seller makes the following representations which are agreed to constitute a material part of the consideration hereunder, upon which Purchaser is relying in entering into this transaction, which are true and accurate as of the execution of this Agreement, and which shall survive the closing. Except as set forth herein and in the Statutory Warranty Deed issued at closing, Seller makes no warranties or representations regarding the Property and the Seller accepts the Property "as is".

a.) Property Condition. Seller represents to the best of Seller's knowledge that Seller is not aware of any material facts adversely affecting the property. Seller additionally represents that all water and mineral rights, if any, are transferable to Buyer and are not encumbered or restricted in any fashion.

b.) Organizational Status. Seller is an entity duly organized, validly existing and in good standing under the laws of the state of Washington, and has full power and authority to enter into and to perform its obligations under this Agreement. The persons executing this Agreement on behalf of Seller have full power and authority to do so and to perform every act and to execute and deliver every document and instrument necessary or appropriate to complete the transactions contemplated hereby. Seller has all necessary power and authority to own its properties and to conduct its business as now owned and conducted by Seller.

c.) Entity Action. All action on the part of Seller which is required for the execution, delivery and performance by Seller of this Agreement and each of the documents and agreements to be delivered by Seller at the closing has been duly and effectively taken.

d.) Enforceable Nature of Agreement. This Agreement and each of the documents and agreements to be delivered by Seller at the closing constitute a legal, valid, and binding obligation of Seller, enforceable against Seller in accordance with its terms.

e.) Violations, Consents, Defaults. Neither the execution of this Agreement nor the performance hereof by Seller will result in any breach or violation of the terms of any law, rule, ordinance, or regulation or of any decree, judgment or order to which Seller is party in effect from any court or governmental body. There are no consents, waivers, authorizations or approvals from any third party necessary to be obtained by Seller in order to carry out the transactions contemplated by this Agreement. The execution and delivery of this Agreement and performance hereof by Seller will not conflict with, or result in a breach of, any of the terms, conditions, or provisions of, or constitute a default under or result in the creation of any new or the acceleration of any existing lien, charge, or encumbrance upon the Property, or any indenture, mortgage, lease, agreement or other instrument to which Seller is a party or by which Seller or any of its assets may be bound.

f.) Litigation. Seller is not a party to any pending or threatened action, suit, proceeding or investigation, at law or in equity or otherwise, in, for or by any court or governmental board, commission, agency, department or officer arising from or relating to the Property or to the past or present operations and activities of Seller upon or relating to the Property. Seller is not subject to nor does any basis exist for, any order, judgment, decree or governmental restriction which would adversely affect either the Property or the use thereof in the manner presently being conducted by Seller. Seller is not aware of any plan, study, litigation, action, proceeding or effort by any

governmental authority or private party which in any way challenges, affects or would challenge or affect the continuation of the present use and operation of the Property.

g.) Governmental Restrictions. Seller has not received, nor is aware of, any notifications, restrictions, or stipulations from the United States of America, the State of Washington, the County of Benton, or any other governmental authority threatening the use of the Property. There are no pending or threatened condemnation proceedings affecting any portion of the Property.

h.) Title and Access. Fee simple title to the Property is currently vested in Seller and will be free and clear of all liens except as set forth in Sections 4 and 5 herein.

i.) Taxes. Seller does not have any liability for any taxes, or any interest or penalty in respect thereof, of any nature that may be assessed against Purchaser or that are or may become a lien against the Property.

j.) Accuracy of Information. To the best of Seller's knowledge after reasonable inquiry, the information furnished by Seller to Purchaser in accordance with the provisions of this Agreement is true, complete and accurate.

k.) Information. There is no information or document not disclosed or provided by Seller to Purchaser, directly or indirectly relating to this transaction or to the ownership or use of the Property.

9. CLOSING: This sale shall be closed by Cascade Title Company no later than December 11, 2009. "Closing" means the date on which all documents are recorded and the sale proceeds are available for disbursement to Seller. Buyer and Seller shall deposit with closing agent all documents and monies required to complete this sale in accordance with this Agreement.

10. CLOSING COSTS AND PRORATIONS: Closing costs shall be allocated as follows:

Seller	Buyer
½ Recording Costs	½ Recording Costs
½ Escrow	½ Escrow
Excise Tax	
Title Insurance	

a.) Items to be Prorated. Taxes for the current year, rents, insurance, interest and utilities constituting liens shall be prorated as of the date of closing.

11. POSSESSION: Buyer shall be entitled to possession of subject property immediately after Closing.

12. CASUALTY LOSS: If, prior to closing, the property is destroyed or materially damaged by any means, Buyer may elect to terminate this Agreement and the earnest money shall be refunded to Buyer.

13. ASSIGNMENT: Buyer's rights under this Agreement may be assigned by Buyer without Seller's consent.

14. FIRPTA COMPLIANCE: This sale may be subject to the withholding and reporting requirements of the Foreign Investment In Real Property Tax Act (FIRPTA), unless Seller furnishes to Buyer an affidavit of non-foreign status. Seller and Buyer agree to comply with FIRPTA, if applicable. Members of Seller are

U.S. citizens. Buyer is a U.S. citizen.

15. NOTICES: All notices, consents, requests, instructions, approvals, demands and other communications provided for herein shall be validly given, made or served if in writing and delivered personally by hand, by a nationally recognized overnight courier service (i.e., Federal Express or United Parcel Service), by United States certified or registered first class mail, postage prepaid with return receipt requested or by facsimile transmission. Each such notice, consent, request, instruction, approval, demand or other communication shall be effective (a) if delivered personally by hand or by a nationally recognized overnight courier service, when delivered at the address specified below; (b) if given by United States certified or registered first class mail, on the date appearing on the return receipt therefor; and (c) if given by facsimile transmission, when such facsimile transmission is transmitted to the facsimile transmission number specified below and the appropriate confirmation is received. In the event that a party is unable to deliver a notice, consent, request, instruction, approval, demand, or other communication due to the inaccuracy of the address or facsimile transmission number provided by the other party pursuant to this Section, or the other party's failure to notify the party of a change of its address or facsimile transmission number as specified pursuant to this Section, such notice, consent, request, instruction, approval, demand, or other communication shall be deemed to be effective upon confirmation by a nationally recognized overnight courier service of its failure to complete delivery to the other party's address as set forth below (or other address duly given to the party by the other party in accordance with this Section).

Addresses and facsimile transmission numbers for notices (unless and until written notice is given of any other address or facsimile transmission number):

If to Purchaser:

Rand Wortman
Kadlec Regional Medical Center
888 Swift Blvd.
Richland, WA 99352
Facsimile: (509) 942-2679

With a Copy to:

Kenneth A. Miller
Miller, Mertens & Comfort, P.L.L.C.
1020 North Center Parkway, Suite B
Kennewick, WA 99336
Facsimile: (509) 374-4229

If to Seller:

Joan H. Moore, Trustee
John M. Moore Non-Exempt Marital Trust
601 W. Main Ave., Ste 400
Spokane, WA 99201
Facsimile: (509) 353-2278

And to:

Washington Trust Bank,
Successor Trustee Under the Will of Frances Paulsen Moore
PO Box 2127
Spokane, WA 99201
Facsimile: (509) 353-2278

16. COMPUTATION OF TIME: Unless otherwise expressly specified herein, any period of time specified in this Agreement shall expire at 4:00 p.m. of the last calendar day of the specified period of time, unless the last day is Saturday, Sunday or a legal holiday, as prescribed in RCW 1.16.050, in which event the specified period of time shall expire at 4:00 pm. of the next business day. Any specified period of seven (7) days or less shall include business days only.

17. DEFAULT: If a dispute should arise regarding the disbursement of any earnest money, the party holding the earnest money may interplead the funds into court. Furthermore, if either Purchaser or Seller defaults, the non-defaulting party may seek specific performance or damages, and the Seller may, under some circumstances, retain the earnest money as liquidated damages. However, the Seller's remedy shall be limited as follows if the paragraph below has been initialed by both parties:

> In the event the Purchaser fails, without legal excuse, to complete the purchase of the property, the earnest money deposit made by the Purchaser shall be forfeited to the Seller as the sole and exclusive remedy available to the Seller for such failure. Furthermore, if the earnest money deposited exceeds five percent (5%) of the sale price, Seller may retain as liquidated damages and as Seller's sole remedy earnest money equaling only five percent (5%) of the purchase price; any additional earnest money shall be refunded to Purchaser.
>
> Purchaser's Initials: _____ Seller's Initials: _____ / _____ / _____

18. GENERAL PROVISIONS: Time is of the essence. There are no verbal agreements which modify this Agreement. This Agreement constitutes the full understanding between Seller and Buyer.

19. CURRENT USE STATUS: If subject property is in a current use status, Buyer will continue the current use status after closing this transaction. If Buyer elects to discontinue the current use status, Buyer will be responsible for any resulting taxes, penalties, and interest associated therewith.

20. ENTIRE AGREEMENT: This document constitutes the entire agreement of the parties. There are no verbal or other agreements which modify or alter this agreement.

21. SURVIVAL. Purchaser and Seller agree that each party and their assigns and successors will be bound by this Agreement and all representations and rights set forth herein shall survive the closing of this Agreement and will not merge into any deed given at closing and shall continue in full force and effect.

22. OFFER TO PURCHASE: Buyer offers to purchase the property on the above terms and conditions. Seller

shall have 14 days after this offer is tendered to Seller or until 4:00 p.m. on October 25, 2009 whichever is later to accept this offer, unless sooner withdrawn. Acceptance by Seller shall not be effective until a signed copy hereof is actually received by Buyer. If this offer is not so accepted, it shall lapse and any deposited earnest money shall be refunded to Buyer.

23. ENVIRONMENTAL CONDITION: As a material consideration to Buyer to enter into this Agreement and transaction and with knowledge that Buyer is specifically relying thereon, Seller makes the following representations and warranties to Purchaser regarding environmental matters, each of which, to the best of Seller's knowledge, is true and accurate as of execution, and, to the best of Seller's knowledge, will be true and accurate as of closing.

a.) Condition of Property. To the best of Seller's knowledge, following all appropriate and due diligent inquiry into the condition of the Property, Seller represents, warrants, and covenants to Buyer that the Property is free from Hazardous Substances, and is not now in violation of any Environmental Law and that no Hazardous Substances (i) are or have been used, treated, stored, disposed of, released, spilled, generated, manufactured, or otherwise handled on the Property, or transported to or from the Property, (ii) have been spilled, released, intruded, leached, or disposed of from the Property onto adjacent property; or (iii) have otherwise come to be located on or beneath the Property, other than those disclosed by Seller

i. To the best of Seller's knowledge, all property adjacent to the Property is and has always been free from Hazardous Substance, and is not and has never been in violation of any Environmental Law.

ii. To the best of Seller's knowledge, there are not now and, have never been any buried or partially buried storage tanks located on the Property.

iii. Seller is not aware of any facts or circumstances which could give rise to a violation of any Environmental Law.

b.) Environmental Liens. No liens have been placed on the Property under any Environmental Laws, and Seller has no knowledge of any threatened or pending liens.

c.) No Notice. Seller has received no notice and is not aware of any administrative or judicial investigations, proceedings, or actions with respect to violations, alleged or proven, of Environmental Laws by Seller or any of its tenants, or otherwise involving the Property or the operations conducted thereon.

d.) Definitions. For purposes of this Agreement, the terms "Environmental Laws" and "Hazardous Substances" shall have the following meanings:

i. Environmental Laws. As used in this Agreement, the term "Environmental Law" shall mean any federal, state or local law, statute, ordinance, or regulation pertaining to health, industrial hygiene, or environmental conditions, including, without limitation, the Comprehensive Environmental Response, Compensation and Liability Act of 1980, 421 U.S.C. §§ 9601 *et seq.;* the Resource Conservation and Recovery Act of 1976, 42 U.S./C. §§ 6901, *et seq.;* The Toxic Substances Control Act of 1976, 15 U.S.C. §§ 2601, *et seq.;* the Superfund Amendments and Reauthorization Act of 1986, Title III, 42 U.S.C. §§ 1101,

et seq.; the Clean Air Act, 42 U.S.C. §§ 7401, *et seq.*, The Federal Water Pollution Control Act, 33 U.S.C. §§ 1251 *et seq.*; the Safe Drinking Water Act, 42 U.S.C. §§ 300f, *et seq.*; the Solid Waste Disposal Act, 42 U.S.C. §§ 3251, *et seq.*; and any other federal, state or local law, statute, ordinance, or regulation now in effect or hereinafter enacted which pertains to health, industrial hygiene, or the regulation or protection of the environment, including, without limitation, ambient air, soil, groundwater, surface water, and/or land use.

ii. Definition of "Hazardous Substance". As used in this Agreement, the term "Hazardous Substance" shall mean any material, waste, substance, pollutant, or contaminant which may or could pose a risk of injury or threat to health of the environment, including, without limitation:

(a) Those substances included within the definitions of "hazardous substance", "hazardous waste", "hazardous material", "toxic substance", "solid waste", or "pollutant or contaminant" in, or otherwise regulated by the Comprehensive Environmental Response, Compensation and Liability Act of 1980; the Resource Conservation and Recovery Act of 1976; the Toxic Substances Control Act of 1976; The Hazardous Materials Transportation Act, 49 U.S.C. §§ 1801 *et seq.*; and in the regulations promulgated pursuant to said laws;

(b) Those substances listed in the United States Department of Transportation Hazardous Materials Table (49 CFR 172.101, including appendices and amendments thereto), or by the Environmental Protection Agency (or any successor agency) as hazardous substances (40 CFR Part 302 and amendments thereto);

(c) Such other substances, materials, or wastes which are or become regulated or classified as hazardous or toxic under federal, state, or local laws or regulations; and

(d) Any material, waste, or substance which is petroleum or refined petroleum products; asbestos in any form; polychlorinated biphenyls; flammable explosives; radioactive materials or radon.

e.) Statutory References and Amendments. Any reference in this Section 24 to statutory or regulatory sections shall be deemed to include any amendments thereto any successor sections.

f.) Separability. Each of the provisions of this Section 24 is separate and distinct and independent of the others. If any such provision shall be held invalid or unenforceable for any reason, such validity or unenforceability shall not affect the validity or enforceability of the other provisions.

24. INDEMNIFICATION. The Seller hereby agrees to unconditionally indemnify, defend, and hold the Buyer and/or their assigns, commissioners, directors, officers, employees, and agents, harmless from, and shall reimburse all such parties for any loss, liability, damage (whether direct or consequential), claims, penalties, fines, injunctions, suits, proceedings, disbursements, or expenses (including, without limitation, attorneys' and experts' fees and disbursements and court costs), arising as a result of a breach by either of any obligation hereunder, including the foregoing representations and warranties.

25. ATTORNEY'S FEES. If either party hereto is required to retain an attorney to enforce any provision of this Agreement, said party shall be entitled to reasonable attorneys' fees regardless of whether the matter

proceeds to judgment or is resolved by defaulting party curing default.

26. LEGAL REPRESENTATION: The parties hereto acknowledge that this Agreement was drafted by Kenneth A. Miller of Miller, Mertens & Comfort, PLLC, and that Kenneth A. Miller represents only Kadlec Regional Medical Center in this transaction. Seller acknowledges that they have been advised to seek their own attorney to advise and counsel them in regard to this Agreement

BUYER: KADLEC REGIONAL MEDICAL CENTER

By:_____
Rand Wortman

888 Swift Blvd., Richland, WA 99352 (509) 942-2022
Buyer's Address Buyer's Phone (Home/Work)

ACCEPTANCE or COUNTER OFFER: On this date, _____, 2009, Seller agrees to sell the property on the terms and conditions set forth in this Agreement and further agrees to pay a commission according to the terms of the listing agreement. The Seller agrees to pay the Selling Broker ___% of the purchase price and Seller assigns to Broker a portion of the sale proceeds equal to the commission, and irrevocably authorizes and instructs the closing agent to disburse the commission directly to Broker at closing. Seller acknowledges receipt of a copy of this Agreement signed by both parties. If Seller has made a counter offer hereon or attached hereon, Buyer shall have until 4:00 p.m. on _____, 2009, to accept the counter offer, unless sooner withdrawn. Acceptance shall not be effective until a signed copy hereof is actually received by or at the office of Broker. If the counter offer is not accepted, it shall lapse and the earnest money shall be refunded to Buyer.

SELLER:

JOHN M. MOORE NON-EXEMPT MARITAL TRUST

By:_____
Joan H. Moore, Trustee

PO Box 2127, Spokane WA 99201 (509)-353-3881
Seller's Address Seller's Phone (Home/Work)

WASHINGTON TRUST BANK,
SUCCESSOR TRUSTEE UNDER THE WILL OF FRANCES PAULSEN MOORE

By:_____ VP By:_____ SVP/OTC

PO Box 2127, Spokane WA 99201 (509)-353-3881
Seller's Address Seller's Phone (Home/Work)

RECEIPT: On this date: Oct 22, 2009, Buyer acknowledges receipt of a copy of this Agreement signed by both parties. If Seller has made a counter offer, Buyer accepts the counter offer.

BUYER: KADLEC REGIONAL MEDICAL CENTER

By: _____
Rand Wortman

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proceeds to judgment or is resolved by defaulting party curing default.

26. LEGAL REPRESENTATION: The parties hereto acknowledge that this Agreement was drafted by Kenneth A. Miller of Miller, Mertens & Comfort, PLLC, and that Kenneth A. Miller represents only Kadlec Regional Medical Center in this transaction. Seller acknowledges that they have been advised to seek their own attorney to advise and counsel them in regard to this Agreement

BUYER: KADLEC REGIONAL MEDICAL CENTER

By:_____
Rand Wortman

888 Swift Blvd., Richland, WA 99352 (509) 942-2022
Buyer's Address Buyer's Phone (Home/Work)

ACCEPTANCE or COUNTER OFFER: On this date, October 14, 2009, Seller agrees to sell the property on the terms and conditions set forth in this Agreement and further agrees to pay a commission according to the terms of the listing agreement. The Seller agrees to pay the Selling Broker ___% of the purchase price and Seller assigns to Broker a portion of the sale proceeds equal to the commission, and irrevocably authorizes and instructs the closing agent to disburse the commission directly to Broker at closing. Seller acknowledges receipt of a copy of this Agreement signed by both parties. If Seller has made a counter offer hereon or attached hereon, Buyer shall have until 4:00 p.m. on _____, 2009, to accept the counter offer, unless sooner withdrawn. Acceptance shall not be effective until a signed copy hereof is actually received by or at the office of Broker. If the counter offer is not accepted, it shall lapse and the earnest money shall be refunded to Buyer.

SELLER:

JOHN M. MOORE NON-EXEMPT MARITAL TRUST

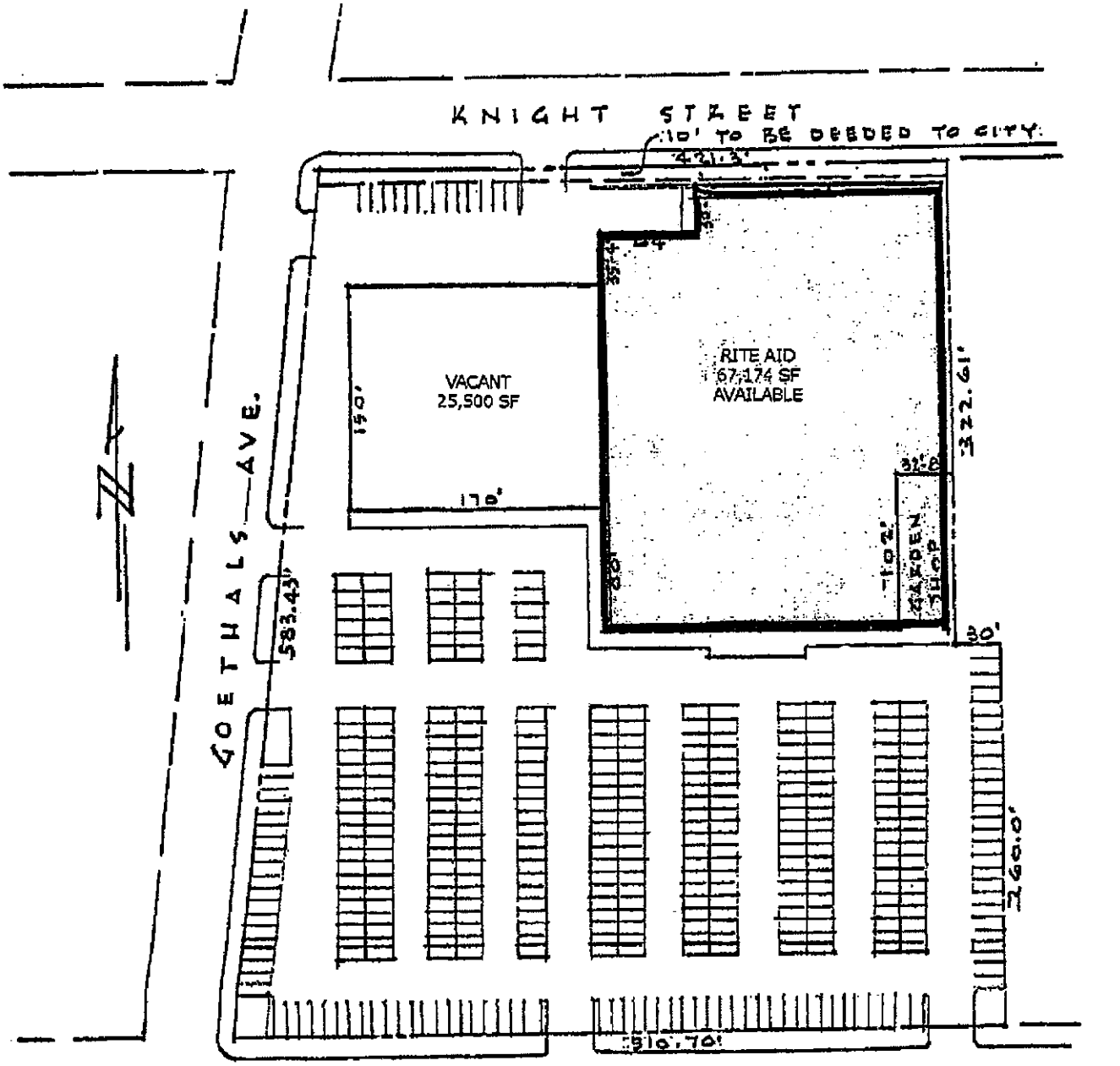
By:_____
Joan H. Moore, Trustee

PO Box 2127, Spokane WA 99201 (509)-353-3881
Seller's Address Seller's Phone (Home/Work)

WASHINGTON TRUST BANK,
SUCCESSOR TRUSTEE UNDER THE WILL OF FRANCES PAULSEN MOORE

By:_____

PO Box 2127, Spokane WA 99201 (509)-353-3881
Seller's Address Seller's Phone (Home/Work)



PLOT PLAN

SCALE 1" = 100'

BUILDING AREA 92,801.76 S.F.

PROPERTY AREA (APPROX.) 279,296.00 S.F.

CAR PARKING SPACES 396

SITE DESCRIPTION

Location:	1268 and 1270 Lee Boulevard, Richland, WA.
Size:	
1-1198-302-0628-006	4.05 acres (176,418 SF)
1-1198-302-0628-00F	2.03 acres (88,383 SF)
Total	6.08 acres (264,801 SF)
	The parcel improved with the former Rite Aid/Payless store is the larger of the two sites.
Topography:	Level
Hazardous Waste:	PGP Valuation Inc. has not conducted an independent investigation to determine the presence of absence of toxins on the subject property. If questions arise, the reader is advised to seek qualified professional assistance in this matter. Please see the Assumptions and Limiting Conditions for a full disclaimer.
Adjacent Properties:	
North:	Knight Street then a new building for Columbia Basin College
West:	Goethals Street then commercial uses including Jerry's Place and Taco Del Mar
East:	Bank of America and Barons Roast Beef restaurant
South:	Lee Boulevard then Key Bank, Zips fast food restaurant and a flower shop
Utilities:	All utilities are available to the site.
Street Improvements:	Lee Boulevard is an east – west arterial through central Richland. The other 2 abutting streets have lower traffic counts.
Accessibility/Exposure:	Access to the subject site is good overall. Exposure of the subject is good, although Lee Boulevard is no longer viewed as an arterial which favors retail.
Easements:	A title report was not available. No unusual circumstances were noted during a site inspection, aside from the expectation that tenants of each building have the right to cross both parcels. If questions arise, further research is advised.

Zoning:

The subject site is zoned C – 2 (Retail Business District). "The Retail Business Use District (C-2) is a business zone classification providing for a wide range of retail business uses and services compatible to the core of the City and providing a focal point for the commerce of the City." A wide range of uses are allowed: including hospitals, public uses such as schools, medical and professional office, hotels, apartments, condos, and a wide range of retail uses including large format stores.

Zoning information from the city of Richland's website is included in the Addenda. The only zone in the city that allows a broader range of uses is the C – 3 zone, which allows more industrial uses than the subject's C – 2 zone. The subject's current use is an allowed use. The most likely alternative uses (based on surrounding land use patterns), office, medical office, and public uses are also allowed.

Soils:

Based on surrounding improved properties, it assumed the soils are stable. No unusual circumstances were noted. No further information was available.

Earthquake Zone:

According to the Washington State Department of Natural Resources, Benton County is located in Seismic Zone 2B. Zone 2B is a medium risk area.

Site Rating:

The subject's main advantage is its location near Kadlec Hospital and the city of Richland's main campus. These institutions would be potential buyers for a large site at this location. Most of the retail in Richland has shifted to other nodes (Queensgate is an example), which is a factor in the conclusion that the existing use is no longer the highest and best use.

Exhibit 15
Bed Need Methodology

Benton-Franklin Planning Area Bed Need Methodology, CHARS 2017, OFM Estimates
Excludes Psych (MDC 19), Neonates (DRGs 385-391/789-795), and Rehab (DRGs 462/945 and 946) and All WA State Rehab Providers
Step 1

TOTAL NUMBER OF RESIDENT PATIENT DAYS
Excludes MDC 19 (Psych), DRGs 385-391/789-795 (Neonates) and DRG 462/945 and 946 (Rehab) and All WA State Rehab Providers

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Annual Growth Rate
HSA3	241,310	242,460	242,221	241,102	233,162	233,097	229,491	237,957	242,692	253,940	0.57%
Benton-Franklin	67,019	71,622	73,628	71,623	69,663	73,344	74,718	79,800	79,028	86,717	2.86%
STATEWIDE TOTAL	2,063,894	2,060,569	2,045,598	2,058,497	2,045,174	2,059,668	2,108,366	2,205,734	2,255,464	2,323,924	1.32%

Source: CHARS 2008-2017
*Note: Does not include out-migration to other states

Benton-Franklin Planning Area Bed Need Methodology, CHARS 2017, OFM Estimates
Excludes Psych (MDC 19), Neonates (DRGs 385-391/789-795), and Rehab (DRGs 462/945 and 946) and All WA State Rehab Providers
Step 2

2007-2016 TOTAL NUMBER OF PATIENT DAYS
Excludes MDC 19 (Psych), DRGs 385-391/789-795 (Neonates) and DRG 462/945 and 946 (Rehab) and All WA State Rehab Providers

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
HSA3	241,310	242,460	242,221	241,102	233,162	233,097	229,491	237,957	242,692	253,940
Benton-Franklin	67,019	71,622	73,628	71,623	69,663	73,344	74,718	79,800	79,028	86,717
STATEWIDE TOTAL	2,063,894	2,060,569	2,045,598	2,058,497	2,045,174	2,059,668	2,108,366	2,205,734	2,255,464	2,323,924

2007-2016 TOTAL NUMBER OF PSYCHIATRIC PATIENT DAYS
In Psychiatric Hospitals. 'Excludes MDC 19 (Psych), DRGs 385-391/789-795 (Neonates) and DRG 462/945 and 946 (Rehab) and All WA State Rehab Providers
Psychiatric hospitals: BHC Fairfax, BHC Fairfax North, BHC Fairfax Monroe, Cascade Behavioral Health, West Seattle Psychiatric and Puget Sound Behavioral Health in HSA1, and

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
HSA3	28	100	104	159	158	237	324	575	590	902
Benton-Franklin	11	77	96	118	88	176	260	318	282	663
STATEWIDE TOTAL	1,255	2,129	1,571	1,916	3,202	3,462	11,223	18,464	17,802	20,156

2007-2016 TOTAL NUMBER OF PATIENT DAYS MINUS PSYCH DAYS
Excludes MDC 19 (Psych), DRGs 385-391/789-795 (Neonates) and DRG 462/945 and 946 (Rehab) and days in Psychiatrics Hospitals and and All WA State Rehab Providers

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
HSA3	241,282	242,360	242,117	240,943	233,004	232,860	229,167	237,382	242,102	253,038
Benton-Franklin	67,008	71,545	73,532	71,505	69,575	73,168	74,458	79,482	78,746	86,054
STATEWIDE TOTAL	2,062,639	2,058,440	2,044,027	2,056,581	2,041,972	2,056,206	2,097,143	2,187,270	2,237,662	2,303,768

Source: CHARS 2008-2017
*Note: Does not include out-migration to other states

Benton-Franklin Planning Area Bed Need Methodology, CHARS 2017, OFM Estimates
Excludes Psych (MDC 19), Neonates (DRGs 385-391/789-795), and Rehab (DRGs 462/945 and 946) and All WA State Rehab Providers
Step 3

TOTAL NUMBER OF PATIENT DAYS MINUS PSYCH DAYS
Excludes MDC 19 (Psych), DRGs 385-391/789-795 (Neonates) and DRG 462/945 and 946 (Rehab) and days in Psychiatrics Hospitals and and All WA State Rehab Providers

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Annual Growth Rate
HSA3	241,282	242,360	242,117	240,943	233,004	232,860	229,167	237,382	242,102	253,038	0.53%
Benton-Franklin	67,008	71,545	73,532	71,505	69,575	73,168	74,458	79,482	78,746	86,054	2.78%
STATEWIDE TOTAL	2,062,639	2,058,440	2,044,027	2,056,581	2,041,972	2,056,206	2,097,143	2,187,270	2,237,662	2,303,768	1.23%

TOTAL POPULATIONS

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Annual Growth Rate
HSA3	755,103	767,841	778,610	787,050	794,525	803,530	812,600	819,190	826,750	837,550	1.15%
Benton-Franklin	239,828	246,513	253,340	258,400	262,500	268,200	273,100	275,740	279,170	283,830	1.87%
STATEWIDE TOTAL	6,608,234	6,672,263	6,724,540	6,767,900	6,817,770	6,882,400	6,968,170	7,061,410	7,183,700	7,310,300	1.12%

USE RATE PER 1,000
Excludes MDC 19 (Psych), DRGs 385-391/789-795 (Neonates) and DRG 462/945 and 946 (Rehab) and days in Psychiatrics Hospitals and and All WA State Rehab Providers

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Annual Growth Rate
HSA3	319.5	315.6	311.0	306.1	293.3	289.8	282.0	289.8	292.8	302.1	-0.62%
Benton-Franklin	279.4	290.2	290.3	276.7	265.0	272.8	272.6	288.2	282.1	303.2	0.91%
STATEWIDE TOTAL	312.1	308.5	304.0	303.9	299.5	298.8	301.0	309.7	311.5	315.1	0.11%

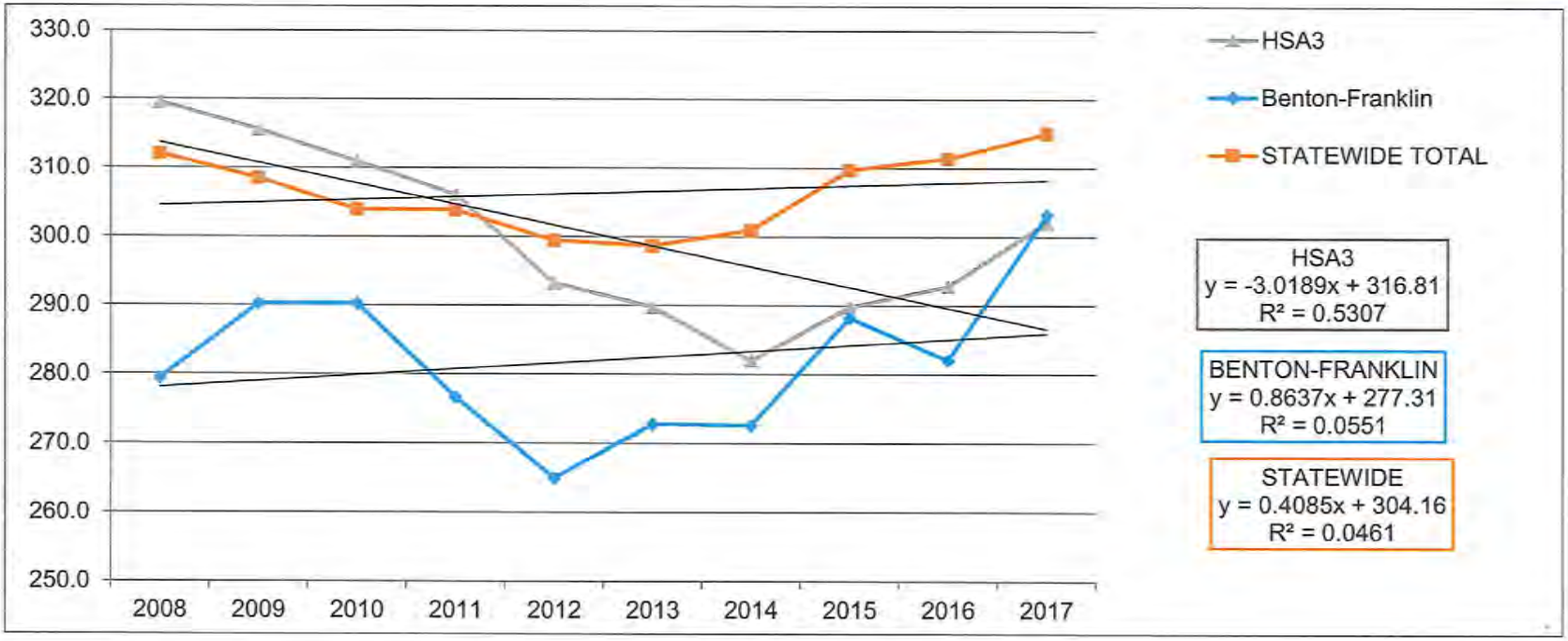
Source: CHARS 2008-2017; OFM SADE Estimates 2008-2017; OFM Medium Series (2017), and OFM Forecast of the State Population by Age and Sex (2017 Release)
*Note: Does not include out-migration to other states

Benton-Franklin Planning Area Bed Need Methodology, CHARS 2017, OFM Estimates
Excludes Psych (MDC 19), Neonates (DRGs 385-391/789-795), and Rehab (DRGs 462/945 and 946) and All WA State Rehab Providers
Step 4

USE RATE PER 1,000

Excludes MDC 19 (Psych), DRGs 385-391/789-795 (Neonates) and DRG 462/945 and 946 (Rehab) and days in Psychiatrics Hospitals and and All WA State Rehab Providers

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Slope
HSA3	319.5	315.6	311.0	306.1	293.3	289.8	282.0	289.8	292.8	302.1	-3.019
Benton-Franklin	279.4	290.2	290.3	276.7	265.0	272.8	272.6	288.2	282.1	303.2	0.864
STATEWIDE TOTAL	312.1	308.5	304.0	303.9	299.5	298.8	301.0	309.7	311.5	315.1	0.409



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

Benton-Franklin Planning Area Bed Need Methodology, CHARS 2017, OFM Estimates
Excludes Psych (MDC 19), Neonates (DRGs 385-391/789-795), and Rehab (DRGs 462/945 and 946) and All WA State Rehab Providers
Step 5

STEP #5
2016 DATA

	Total Patient Days	Out of State Residents	WA Residents	Out of State as % of WA Residents
To Benton-Franklin Hospitals				
0-64	47,098	4,859	42,239	11.50%
65+	43,114	4,366	38,748	11.27%
TOTAL	**90,212**	**9,225**	**80,987**	**11.39%**
To WA - Planning Area Hospitals				
0-64	1,270,340	59,734	1,210,606	4.93%
65+	1,070,618	38,287	1,032,331	3.71%
TOTAL	**2,340,958**	**98,021**	**2,242,937**	**4.37%**
Total patient days to WA Hospitals	**2,431,170**	**107,246**	**2,323,924**	**4.61%**

MARKET SHARE
PERCENTAGE OF PATIENT DAYS

	TO Benton-Franklin	TO WA - Planning Area	To Oregon Hospitals
% OF Benton-Franklin Residents			
0-64	73.81%	24.51%	1.68%
65+	89.09%	10.34%	0.57%
TOTAL	**80.53%**	**18.27%**	**1.19%**
% OF WA - Planning Area Residents			
0-64	0.48%	96.70%	2.82%
65+	0.41%	97.57%	2.02%
TOTAL	**0.45%**	**97.10%**	**2.45%**

	TO Benton-Franklin Hospitals	TO WA - Planning Area Hospitals	Days in Oregon hospitals	Total Days for Residents
Washington Residents FROM Benton-Franklin				
0-64	36,266	12,043	826	49,135
65+	34,413	3,995	219	38,627
TOTAL	**70,679**	**16,038**	**1,045**	**87,762**
FROM WA - Planning Area				
0-64	5,973	1,198,563	34,946	1,239,482
65+	4,335	1,028,336	21,313	1,053,984
TOTAL	**10,308**	**2,226,899**	**56,259**	**2,293,466**
Totals:	**80,987**	**2,242,937**	**57,304**	**2,381,228**

POPULATIONS BY Benton-Franklin

	Benton-Franklin	WA - Planning Area	Total Pop WA
0-64	246,517	5,942,004	6,188,521
65+	37,313	1,084,466	1,121,779
TOTAL	**283,830**	**7,026,470**	**7,310,300**

WA Source: CHARS 2016 'Excludes MDC 19 (Psych), DRGs 789-795 (Neonates) and DRG 945 and 946 (Rehab) and All WA State Rehab Providers; OFM SADE Estimate 2017
Oregon Source: Oregon Hospital Discharge Data 2015, excludes DRGs 876 and 880-887 (Psych), DRGs 789-795 (Neonates), and DRGs 945 and 946 (Rehab)

Benton-Franklin Planning Area Bed Need Methodology, CHARS 2017, OFM Estimates
Excludes Psych (MDC 19), Neonates (DRGs 385-391/789-795), and Rehab (DRGs 462/945 and 946) and All WA State Rehab Providers
Step 6

2017 Data
USE RATE BY PLANNING AREA (defined as age specific inpatient days per 1,000 population)

	Benton-Franklin	WA - Planning Area
USE RATES		
0-64	199.32	208.60
65+	1,035.22	971.89

Benton-Franklin Planning Area Bed Need Methodology, CHARS 2017, OFM Estimates
Excludes Psych (MDC 19), Neonates (DRGs 385-391/789-795), and Rehab (DRGs 462/945 and 946) and All WA State Rehab Providers
Step 7

USE RATE BY Benton-Franklin Planning Area FROM STEP 6

	2017
BASE YEAR USE RATES	
0-64	199.32
65+	1,035.22

		2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031
Benton-Franklin Planning Area															
PROJECTED USE RATES*															
0-64 using HSA Trend		196.30	193.28	190.26	187.24	184.22	181.20	178.18	175.17	172.15	169.13	166.11	163.09	160.07	157.05
0-64 using Statewide Trend		**199.73**	**200.13**	**200.54**	**200.95**	**201.36**	**201.77**	**202.18**	**202.58**	**202.99**	**203.40**	**203.81**	**204.22**	**204.63**	**205.04**
65+ using HSA Trend		1,032.20	1,029.18	1,026.17	1,023.15	1,020.13	1,017.11	1,014.09	1,011.07	1,008.05	1,005.03	1,002.01	999.00	995.98	992.96
65+ using Statewide Trend		**1,035.63**	**1,036.04**	**1,036.45**	**1,036.86**	**1,037.26**	**1,037.67**	**1,038.08**	**1,038.49**	**1,038.90**	**1,039.31**	**1,039.72**	**1,040.12**	**1,040.53**	**1,040.94**

*State Health Plan specifies projected by applying either the HSA trend or Statewide trend, whichever trend would result in the smaller adjustment
Bold Print indicates use rate closest to current value

Benton-Franklin Planning Area Bed Need Methodology, CHARS 2017, OFM Estimates
Excludes Psych (MDC 19), Neonates (DRGs 385-391/789-795), and Rehab (DRGs 462/945 and 946) and All WA State Rehab Providers
Step 8

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031
Benton-Franklin Planning Area															
(using Trend slope from Step 4 for future year adjustments)															
USE RATES															
0-64	199.32	199.73	200.13	200.54	200.95	201.36	201.77	202.18	202.58	202.99	203.40	203.81	204.22	204.63	205.04
65+	1,035.22	1,035.63	1,036.04	1,036.45	1,036.86	1,037.26	1,037.67	1,038.08	1,038.49	1,038.90	1,039.31	1,039.72	1,040.12	1,040.53	1,040.94
PROJECTED POPULATION															
0-64	246,517	249,958	253,460	259,517	263,292	267,135	271,049	275,033	279,278	282,866	286,512	290,215	293,978	297,956	302,150
65+	37,313	38,885	40,523	41,760	43,303	44,904	46,565	48,287	50,244	51,624	53,042	54,501	56,001	57,653	58,709
TOTALS	**283,830**	**288,842**	**293,984**	**301,277**	**306,595**	**312,039**	**317,613**	**323,321**	**329,522**	**334,490**	**339,554**	**344,716**	**349,979**	**355,609**	**360,859**
										0	0	0	0	0	0
PROJECTED # OF PATIENT DAYS for Benton-Franklin Planning Area Residents															
0-64	49,135	49,923	50,726	52,044	52,909	53,790	54,689	55,605	56,578	57,420	58,277	59,149	60,036	60,970	61,952
65+	38,627	40,270	41,984	43,282	44,899	46,577	48,319	50,126	52,178	53,632	55,127	56,666	58,248	59,990	61,112
TOTALS	**87,762**	**90,193**	**92,710**	**95,326**	**97,808**	**100,367**	**103,008**	**105,731**	**108,755**	**111,052**	**113,404**	**115,815**	**118,284**	**120,960**	**123,064**

Source: OFM Medium Series (2017)

Benton-Franklin Planning Area Bed Need Methodology, CHARS 2017, OFM Estimates
Excludes Psych (MDC 19), Neonates (DRGs 385-391/789-795), and Rehab (DRGs 462/945 and 946) and All WA State Rehab Providers
Step 9

9 A--Resident Day Calculations

Planning Area Days	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031
0-64	49,135	49,923	50,726	52,044	52,909	53,790	54,689	55,605	56,578	57,420	58,277	59,149	60,036	60,970	61,952
65+	38,627	40,270	41,984	43,282	44,899	46,577	48,319	50,126	52,178	53,632	55,127	56,666	58,248	59,990	61,112
TOTALS	**87,762**	**90,193**	**92,710**	**95,326**	**97,808**	**100,367**	**103,008**	**105,731**	**108,755**	**111,052**	**113,404**	**115,815**	**118,284**	**120,960**	**123,064**
Planning Area Population															
0-64	246,517	249,958	253,460	259,517	263,292	267,135	271,049	275,033	279,278	282,866	286,512	290,215	293,978	297,956	302,150
65+	37,313	38,885	40,523	41,760	43,303	44,904	46,565	48,287	50,244	51,624	53,042	54,501	56,001	57,653	58,709
TOTALS	**283,830**	**288,842**	**293,984**	**301,277**	**306,595**	**312,039**	**317,613**	**323,321**	**329,522**	**334,490**	**339,554**	**344,716**	**349,979**	**355,609**	**360,859**
WA Population (OFM Forecast)															
0-64	6,188,521	6,252,727	6,310,203	6,359,225	6,404,617	6,444,425	6,480,657	6,517,169	6,550,207	6,585,612	6,624,307	6,663,793	6,706,688	6,752,072	6,803,281
65+	1,121,779	1,173,619	1,225,307	1,279,190	1,331,623	1,383,449	1,435,375	1,484,307	1,534,836	1,583,436	1,628,641	1,672,928	1,713,532	1,751,106	1,780,865
TOTALS	**7,310,300**	**7,426,346**	**7,535,510**	**7,638,415**	**7,736,240**	**7,827,874**	**7,916,032**	**8,001,476**	**8,085,043**	**8,169,048**	**8,252,948**	**8,336,721**	**8,420,220**	**8,503,178**	**8,584,146**
WA- Planning Area Population															
0-64	5,942,004	6,002,769	6,056,743	6,099,708	6,141,325	6,177,290	6,209,608	6,242,136	6,270,929	6,302,746	6,337,795	6,373,578	6,412,710	6,454,116	6,501,131
65+	1,084,466	1,134,734	1,184,784	1,237,430	1,288,320	1,338,545	1,388,810	1,436,020	1,484,592	1,531,812	1,575,599	1,618,427	1,657,531	1,693,453	1,722,156
TOTALS	**7,026,470**	**7,137,504**	**7,241,526**	**7,337,138**	**7,429,645**	**7,515,835**	**7,598,419**	**7,678,155**	**7,755,521**	**7,834,558**	**7,913,394**	**7,992,005**	**8,070,241**	**8,147,569**	**8,223,287**
WA-Planning Area Use Rate, based on the same trend adjustment used for the Planning Area (Step 4)															
0-64	208.6	209.0	209.4	209.8	210.2	210.6	211.0	211.5	211.9	212.3	212.7	213.1	213.5	213.9	214.3
65+	971.9	972.3	972.7	973.1	973.5	973.9	974.3	974.8	975.2	975.6	976.0	976.4	976.8	977.2	977.6
WA-Planning Area Patient Days															
0-64	1,239,482	1,254,610	1,268,365	1,279,854	1,291,095	1,301,180	1,310,524	1,319,939	1,328,590	1,337,905	1,347,935	1,358,149	1,369,107	1,380,584	1,393,297
65+	1,053,984	1,103,303	1,152,450	1,204,165	1,254,213	1,303,655	1,353,178	1,399,763	1,447,715	1,494,388	1,537,748	1,580,209	1,619,067	1,654,847	1,683,600
TOTALS	**2,293,466**	**2,357,913**	**2,420,815**	**2,484,019**	**2,545,308**	**2,604,835**	**2,663,702**	**2,719,702**	**2,776,305**	**2,832,293**	**2,885,683**	**2,938,358**	**2,988,174**	**3,035,431**	**3,076,896**

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

% OF Planning Area Residents	To Planning Area Hospitals	To WA - Planning Area Hospitals	To Oregon
0-64	73.81%	24.51%	1.68%
65+	89.09%	10.34%	0.57%

% OF WA - Planning Area Residents	To Planning Area Hospitals	To WA - Planning Area Hospitals	To Oregon
0-64	0.48%	96.70%	2.82%
65+	0.41%	97.57%	2.02%

Benton-Franklin Planning Area Bed Need Methodology, CHARS 2017, OFM Estimates
Excludes Psych (MDC 19), Neonates (DRGs 385-391/789-795), and Rehab (DRGs 462/945 and 946) and All WA State Rehab Providers
Step 9

9C Planning Area Resident Patient Days to Planning Area Providers															
	2017	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**
Planning Area Residents To Planning Area Providers															
0-64	36,266	36,847	37,440	38,413	39,051	39,702	40,365	41,042	41,759	42,381	43,014	43,657	44,312	45,001	45,726
65+	34,413	35,877	37,404	38,560	40,001	41,496	43,047	44,658	46,486	47,781	49,113	50,484	51,893	53,445	54,445
TOTALS	**70,679**	**72,724**	**74,844**	**76,973**	**79,052**	**81,198**	**83,413**	**85,699**	**88,245**	**90,162**	**92,127**	**94,141**	**96,205**	**98,447**	**100,171**
Planning Area Residents To Other WA Providers															
0-64	12,043	12,236	12,433	12,756	12,968	13,184	13,404	13,629	13,867	14,074	14,284	14,497	14,715	14,944	15,184
65+	3,995	4,165	4,342	4,476	4,644	4,817	4,997	5,184	5,397	5,547	5,702	5,861	6,024	6,204	6,321
TOTALS	**16,038**	**16,401**	**16,775**	**17,232**	**17,612**	**18,001**	**18,402**	**18,813**	**19,264**	**19,621**	**19,985**	**20,358**	**20,739**	**21,148**	**21,505**
Planning Area Residents To Oregon Providers															
0-64	826	839	853	875	889	904	919	935	951	965	980	994	1,009	1,025	1,041
65+	219	228	238	245	255	264	274	284	296	304	313	321	330	340	346
TOTALS	**1,045**	**1,068**	**1,091**	**1,120**	**1,144**	**1,168**	**1,193**	**1,219**	**1,247**	**1,269**	**1,292**	**1,316**	**1,339**	**1,365**	**1,388**
9D Other WA Resident Patient Days to Planning Area Providers															
	2017	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**
Other WA Residents To Planning Area Providers															
0-64	5,973	6,046	6,112	6,168	6,222	6,270	6,315	6,361	6,402	6,447	6,496	6,545	6,598	6,653	6,714
65+	4,335	4,538	4,740	4,953	5,159	5,362	5,566	5,757	5,954	6,146	6,325	6,499	6,659	6,806	6,925
TOTALS	**10,308**	**10,584**	**10,852**	**11,120**	**11,380**	**11,632**	**11,881**	**12,118**	**12,357**	**12,594**	**12,820**	**13,044**	**13,257**	**13,459**	**13,639**
Other WA Residents To Other WA Providers															
0-64	1,198,563	1,213,191	1,226,492	1,237,602	1,248,472	1,258,224	1,267,260	1,276,364	1,284,729	1,293,737	1,303,435	1,313,312	1,323,909	1,335,007	1,347,300
65+	1,028,336	1,076,455	1,124,406	1,174,862	1,223,693	1,271,932	1,320,249	1,365,700	1,412,486	1,458,023	1,500,328	1,541,756	1,579,668	1,614,577	1,642,630
TOTALS	**2,226,899**	**2,289,646**	**2,350,898**	**2,412,465**	**2,472,165**	**2,530,156**	**2,587,509**	**2,642,064**	**2,697,215**	**2,751,760**	**2,803,763**	**2,855,068**	**2,903,577**	**2,949,584**	**2,989,930**
Other WA Residents To Oregon Providers															
0-64	34,946	35,373	35,760	36,084	36,401	36,686	36,949	37,214	37,458	37,721	38,004	38,292	38,601	38,924	39,283
65+	21,313	22,310	23,304	24,350	25,362	26,362	27,363	28,305	29,275	30,219	31,095	31,954	32,740	33,463	34,045
TOTALS	**56,259**	**57,683**	**59,064**	**60,434**	**61,763**	**63,047**	**64,312**	**65,520**	**66,733**	**67,940**	**69,099**	**70,246**	**71,340**	**72,388**	**73,327**

Benton-Franklin Planning Area Bed Need Methodology, CHARS 2017, OFM Estimates
Excludes Psych (MDC 19), Neonates (DRGs 385-391/789-795), and Rehab (DRGs 462/945 and 946) and All WA State Rehab Providers
Step 9

9E Total WA Resident Patient Days to Planning Area Providers															
	2017	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**
Total Wa Resident Days to Planning Area Providers															
0-64	42,239	42,893	43,552	44,581	45,273	45,972	46,681	47,402	48,162	48,828	49,509	50,202	50,910	51,654	52,440
65+	38,748	40,415	42,144	43,513	45,159	46,858	48,613	50,415	52,440	53,927	55,438	56,983	58,553	60,252	61,370
TOTALS	**80,987**	**83,308**	**85,696**	**88,094**	**90,432**	**92,830**	**95,294**	**97,817**	**100,602**	**102,756**	**104,947**	**107,185**	**109,462**	**111,906**	**113,810**
Total Wa Resident Days to Other WA Providers															
0-64	1,210,606	1,225,427	1,238,925	1,250,359	1,261,440	1,271,408	1,280,664	1,289,993	1,298,596	1,307,811	1,317,719	1,327,809	1,338,624	1,349,951	1,362,484
65+	1,032,331	1,080,620	1,128,748	1,179,339	1,228,336	1,276,749	1,325,247	1,370,885	1,417,882	1,463,570	1,506,030	1,547,616	1,585,692	1,620,782	1,648,951
TOTALS	**2,242,937**	**2,306,047**	**2,367,673**	**2,429,697**	**2,489,777**	**2,548,157**	**2,605,911**	**2,660,878**	**2,716,478**	**2,771,381**	**2,823,749**	**2,875,426**	**2,924,316**	**2,970,732**	**3,011,435**
Total Wa Resident Days to OR Providers															
0-64	35,772	36,212	36,613	36,959	37,291	37,590	37,868	38,149	38,409	38,686	38,983	39,286	39,610	39,949	40,324
65+	21,532	22,539	23,542	24,595	25,616	26,626	27,637	28,589	29,571	30,523	31,408	32,275	33,070	33,803	34,391
TOTALS	**57,304**	**58,750**	**60,155**	**61,554**	**62,907**	**64,216**	**65,505**	**66,738**	**67,980**	**69,209**	**70,391**	**71,561**	**72,680**	**73,753**	**74,715**
9F Total Patient Days Including out of State Residents															
% Out of State Resident Patient Days, 2016 (From Step 5A)															
Planning Area															
0-64	11.50%														
65+	11.27%														
TOTALS	**11.39%**														
Other Washington															
0-64	4.93%														
65+	3.71%														
TOTALS	**4.37%**														
Planning Area Provider Total Patient Days, Including Out of State Residents															
	2017	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**
0-64	*47,098*	*47,828*	*48,563*	*49,709*	*50,481*	*51,261*	*52,051*	*52,855*	*53,702*	*54,445*	*55,205*	*55,977*	*56,766*	*57,596*	*58,473*
65+	*43,114*	*44,969*	*46,892*	*48,416*	*50,248*	*52,138*	*54,091*	*56,095*	*58,349*	*60,004*	*61,685*	*63,404*	*65,150*	*67,041*	*68,285*
TOTALS	***90,212***	***92,796***	***95,455***	***98,125***	***100,729***	***103,398***	***106,141***	***108,951***	***112,051***	***114,449***	***116,889***	***119,381***	***121,916***	***124,637***	***126,757***

Benton-Franklin Planning Area Bed Need Methodology, CHARS 2017, OFM Estimates
Excludes Psych (MDC 19), Neonates (DRGs 385-391/789-795), and Rehab (DRGs 462/945 and 946) and All WA State Rehab Providers
Step 10

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	Average Annual Growth
Benton-Franklin Planning Area	**Forecasts based on Step 4 trendline.**							7-Years								
Population 0-64 (1)	246,517	249,958	253,460	259,517	263,292	267,135	271,049	275,033	279,278	282,866	286,512	290,215	293,978	297,956	302,150	**1.5%**
0-64 Use Rate (2)	199.32	199.73	200.13	200.54	200.95	201.36	201.77	202.18	202.58	202.99	203.40	203.81	204.22	204.63	205.04	**0.2%**
Population 65+ (1)	37,313	38,885	40,523	41,760	43,303	44,904	46,565	48,287	50,244	51,624	53,042	54,501	56,001	57,653	58,709	**3.2%**
65+ Use Rate (2)	1035.22	1035.63	1036.04	1036.45	1036.86	1037.26	1037.67	1038.08	1038.49	1038.90	1039.31	1039.72	1040.12	1040.53	1040.94	**0.0%**
Total Population	283,830	288,842	293,984	301,277	306,595	312,039	317,613	323,321	329,522	334,490	339,554	344,716	349,979	355,609	360,859	**1.7%**
Total Benton-Franklin Planning Area Resident Days	87,762	90,193	92,710	95,326	97,808	100,367	103,008	105,731	108,755	111,052	113,404	115,815	118,284	120,960	123,064	**2.4%**
Total Days in Benton-Franklin Planning Area Hospitals	90,212	92,796	95,455	98,125	100,729	103,398	106,141	108,951	112,051	114,449	116,889	119,381	121,916	124,637	126,757	**2.4%**
Available Beds (3)																
Trios Health	101	101	101	101	101	101	101	101	101	101	101	101	101	101	101	
PMH Medical Center	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	
Kadlec Regional Medical Center	231	231	231	231	231	231	231	231	231	231	231	231	231	231	231	
Lourdes Medical Center	25	25	25	25	25	25	25	25	25	25	25	25	25	25	25	
TOTAL	**372**	**372**	**372**	**372**	**372**	**372**	**372**	**372**	**372**	**372**	**372**	**372**	**372**	**372**	**372**	
Wtd Occ Std (4)	66.49%	66.49%	66.49%	66.49%	66.49%	66.49%	66.49%	66.49%	66.49%	66.49%	66.49%	66.49%	66.49%	66.49%	66.49%	
Gross Bed Need (TPD/365/Occupancy)--Demand	371.71	382.36	393.31	404.31	415.04	426.04	437.34	448.92	461.69	471.57	481.63	491.90	502.34	513.55	522.29	**2.4%**
Bed Supply	372.00	372.00	372.00	372.00	372.00	372.00	372.00	372.00	372.00	372.00	372.00	372.00	372.00	372.00	372.00	
Net Bed Need/Surplus (Demand - Supply)	**-0.29**	**10.36**	**21.31**	**32.31**	**43.04**	**54.04**	**65.34**	**76.92**	**89.69**	**99.57**	**109.63**	**119.90**	**130.34**	**141.55**	**150.29**	

(1) OFM SADE Estimates 2008-2017; OFM Medium Series (2017); Washington State projections - OFM Forecast of the State Population by Age and Sex: 2010-2040 (November 2017 Release)
(2) Use Rate Data Source: CHARS. See Steps 5 & 6. Future use rates adjusted per slope trends from Step 4.
(3) Bed supply sources: 2016 DOH Acute Care Bed Survey; Trios Health 2016 Hospital Year-End Report; Lourdes Medical Center 2017 Hospital Year-End Report

(4) Weighted Occupancy: Calculated per 1987 Washington State Health Plan as the sum, across all hospitals in the planning area, of each hospital's occupancy rate times that hospital's percentage of total beds in the area.

Exhibit 16
Admissions Policy

KADLEC REGIONAL MEDICAL CENTER
HOUSE-WIDE
POLICY AND PROCEDURES
Section: Administration

TITLE: Admitting/Registering Patients	**POLICY:** X **PROCEDURE:** X **GUIDELINE:** **STANDARD:**	**NO. 191.00**
Key Words: Admitting, registration, referral, EMTALA	**EFFECTIVE DATE: 11/12**	**PAGE 1 OF 3**
ADMINISTRATIVE APPROVAL: Lane Savitch, KRMC President	**SUPERSEDES: 1/05,** New	
COMMITTEE APPROVAL/REVIEW: Patient Care Services, Executive Team		
DEVELOPMENT TEAM/AUTHOR(S): Pam Fiskum		
AUDIT REVIEW: (By and Date)		

POLICY:
It is the policy of Kadlec Regional Medical Center (the "Medical Center") to serve as a regional referral center and to provide medically necessary services which may not otherwise be readily available in the region.

PURPOSE:
The purpose of this policy is to establish procedures for making such services appropriately available and to facilitate communication with and/or reports to the patient's physician.

PROCEDURE:

A. Scheduled Services
Requests for Medical Center services which are furnished on a pre-scheduled basis should be directed to OR Scheduling or Central Scheduling . The department will request any necessary medical information, diagnosis, written order, or documentation of medical necessity, if required for such services. Whenever possible, outpatient registration will be completed prior to the date of service.

B. Walk-In Request for Services
For walk-in patients or those who are sent to the Medical Center by another provider and arrive without an appointment, the following procedure will apply:
1. Patient Access will determine the type of service the patient is seeking (e.g. review written order or try to contact patient's physician). If the patient requests emergency services, accompany the patient to the emergency department and follow the Medical Center EMTALA policy.
2. If the patient is not seeking emergency services, determine when the patient can receive the requested services and direct appropriately.
3. See the attached Diagram for Admitting/Registering Patients for a decision tree.

C. Emergency Services
1. Requests for emergency care or emergency medical screening should be handled in accordance with the Medical Center's EMTALA policy.

D. Patient Whose Physician's Lack Privileges at the Medical Center
If the patient's physician is not on staff at the Medical center, the following process will apply:
1. Tests requiring privileges the patient's physician will be listed as the primary care physician referring the patient to the Medical Center.
2. Tests that do not require privileges will be registered and checked in (i.e. lab, X-ray).
3. Each department will determine the appropriate Medical Center physician for such questions.

4. Reports or results of such testing or services will be provided to the patient's physician, in accordance with Medical Center policy.

E. Limitation of Liability
The purposes of this policy are solely to facilitate medically appropriate access to specialty care and communication with referring providers. Nothing in this policy shall be construed as extending the responsibility or liability of Medical Directors or other Medical Center physicians for the medical care and/or medical management of patients, solely by virtue of the registration department identifying a physician on staff as the Medical Center contact physician.

F. Questions
Questions regarding this policy should be directed to the Chief Operating Officer.

Policy 191.00 Attachment A

Diagram For Admitting/Registering Patients

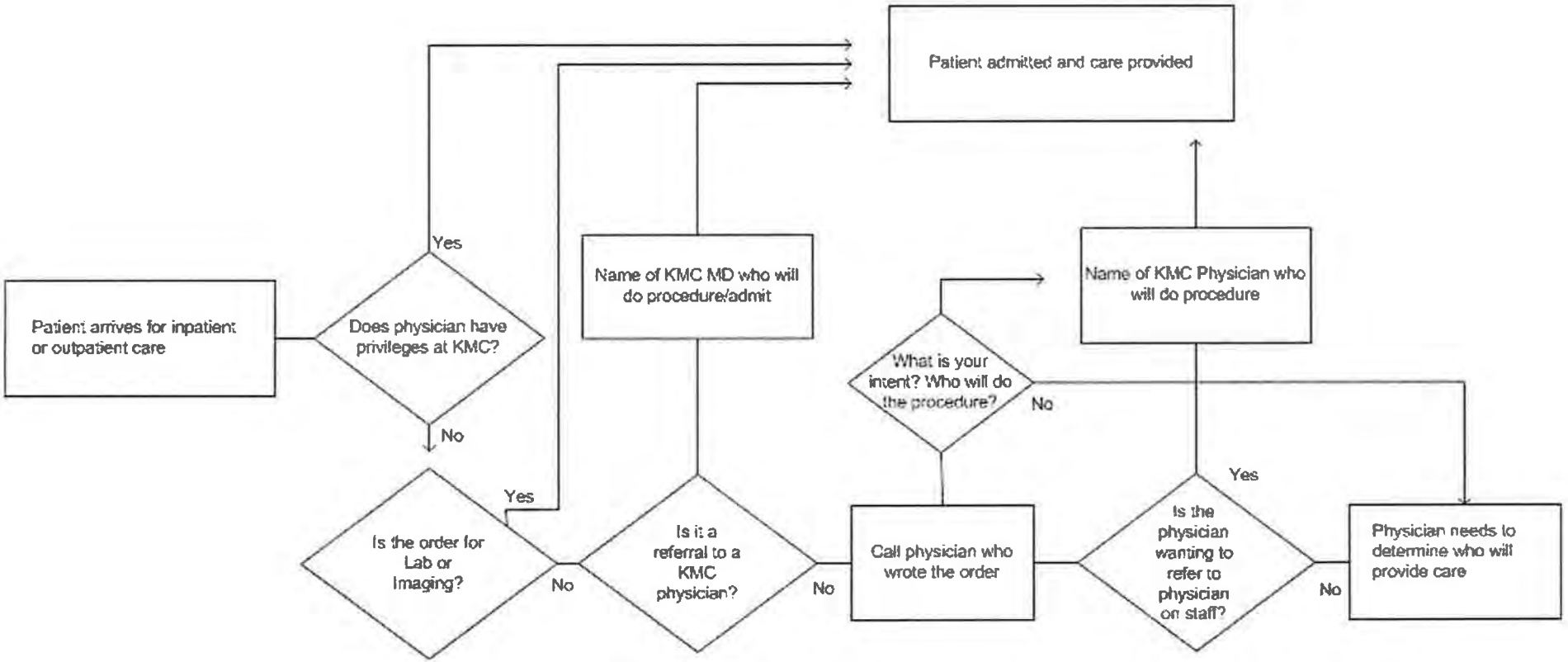


Exhibit 17
Non-Discrimination and Patient Rights and Responsibilities Policy

KADLEC REGIONAL MEDICAL CENTER
HOUSE-WIDE
POLICY AND PROCEDURES
Section: Administration

TITLE: Patient Rights and Responsibilities Patient Nondiscrimination Statement: Adult and Pediatric	**POLICY: X** **PROCEDURE:** **GUIDELINE:** **STANDARD:**	**NO. 160.00**
Key Words: Patient Rights, Advocacy, Nondiscrimination	**EFFECTIVE DATE:** 02/14	**PAGE 1 OF 4**
ADMINISTRATIVE APPROVAL: Lane Savitch, President	**SUPERSEDES:** **05/13,** 12/10, 9/10, 06/08, 7/02, 9/01, 3/95 Policy #1009, 4/90, 5/79, 1/76	
COMMITTEE APPROVAL/REVIEW: Medical Executive Committee 09/10 Board of Directors 11/30/10		
DEVELOPMENT TEAM/AUTHOR(S): Leann Anderson, RN, BS, MHA		
AUDIT REVIEW: (By and Date) HEC 09/10, MEC 09/10,		

Kadlec Regional Medical Center recognizes that entering a hospital can be a confusing and intimidating experience for patients and their families or support persons. This is especially true for pediatric patients (children under 18 years of age). The special needs of pediatric patients include the right to care that is individualized based on age, developmental state, and identified needs. They have the right to an environment that is safe and appropriate for treatment of their specific age group, and access to activities of daily living as much as possible. It is the responsibility of every member of the healthcare team to ensure that every patient or surrogate has the opportunity to exercise their rights in accordance with the applicable law, hospital policy, and accepted standards of patient care.
Furthermore, the hospital recognizes the responsibility to inform and educate the staff members to ensure adherence to these standards of care. Patients also have responsibilities, and it is the responsibility of every patient to make his or her wishes known.

In keeping with our mission to provide quality medical care, as well as demonstrate our concern for patient's well-being Kadlec Regional Medical Center has adopted the following Patients' Rights.

. Notice of Non-discrimination - Kadlec Regional Medical Center, through its employees, medical staff members, residents, interns, contracted service providers and volunteers (collectively referred to in this policy as Kadlec Staff) serve a diverse population and respect the rights of all patients to culturally competent care. Kadlec Staff recognize that each patient is an individual with personal dignity and unique healthcare needs, and provide care focused upon the patient's needs. Kadlec endeavors to have the patient's personal, cultural and spiritual values and beliefs supported when making a decision about treatment.

POLICY:

1. Kadlec Staff will treat all patients who are receiving services, as well as the patient's support person(s), with equality in a welcoming manner that is free from discrimination based on age, race, color, creed, ethnicity, religion, national origin, marital status, sex, sexual orientation, gender identity or expression, disability, veteran or military status, or any other characteristic protected by federal, state, or local law. Kadlec also does not discriminate against patients based upon economic status or the source of payment for care, such as Medicare or Medicaid.

2. Kadlec offers interpretive services to patients and family members with Limited English Proficiency (LEP), including hearing impaired patients or family members who communicate in sign language. Kadlec also endeavors to provide communication aides to patients with vision issues, cognitive impairments, or speech difficulties. Communication will be tailored to an individual's age and needs. Kadlec will provide other reasonable accommodations to patients with disabilities so that the patient has equal opportunity to participate in and to benefit from Kadlec's services.

Please contact Interpreter Services Coordinator for assistance with other needed reasonable accommodations at 800-780-6067 ext. 2817.

3. Kadlec Staff will afford visitation rights to patients free from discrimination based on age, race, color, creed, ethnicity, religion, national origin, marital status, sex, sexual orientation, gender identity or expression, disability, veteran or military status, or any other characteristic protected by federal, state, or local law and will ensure that visitors receive equal visitation privileges consistent with patient preferences.

4. Kadlec Staff will not retaliate against any person who reports concerns about discrimination, files a discrimination complaint, or cooperates in an investigation of discrimination.

5. Any person who believes that he, she, or another person has been subjected to discrimination was denied reasonable accommodation, or experienced retaliation which is not permitted by this Policy, may file a complaint using Kadlec's complaint and grievance procedure.

PROCEDURE:

1. Kadlec's [Corporate Compliance Officer] is responsible for coordinating compliance with this Policy, including giving notice to and training all Kadlec Staff on this Policy.

2. Kadlec Staff will determine eligibility for and provide services, financial aid, and other benefits to all patients in a similar manner, without subjecting any individual to separate or different treatment on the basis of age, race, color, creed, ethnicity, religion, national origin, marital status, sex, sexual orientation, gender identity or expression, disability, veteran or military status, or any other characteristic protected by federal, state, or local law.

3. Kadlec will post this Nondiscrimination Policy on its website, and provide other notices to patients regarding this Nondiscrimination Policy, as well as Kadlec's commitment to providing access to and the provision of services in a welcoming, nondiscriminatory manner.

4. At the time patients are notified of their patient rights, Kadlec Staff will also inform each patient, or the patient's support person when appropriate, of the patient's visitation rights, including any clinical restriction on those rights, and the patient's right, subject to the patient's consent, to receive visitors whom the patient designates, free of discrimination based upon age, race, color, creed, ethnicity, religion, national origin, marital status, sex, sexual orientation, gender identity or expression, disability, veteran or military status, or any other characteristic protected by federal, state, or local law. Such visitors include a spouse, state registered domestic partner (including same-sex state registered domestic partner), another family member, or friend. Kadlec Staff will also notify patients of their right to withdraw or deny such consent at any time. Kadlec Staff will afford such visitors equal visitation privileges consistent with the patient's preferences.

5. Kadlec Staff receiving a patient or visitor discrimination complaint should advise the complaining individual that he or she may report the problem to Compliance Officer [insert job title and contact information] at ext. 2884 and file a complaint without fear of retaliation. Staffs who receive such complaints should also promptly notify Kadlec's [Corporate Compliance Officer] of the complaint.

PATIENT RIGHTS

Access to Care and Treatment - The patient has the right to have a family member or representative of their choice and their own physician notified promptly of their admission to the hospital. If are unable to pay for hospital care, the medical center will provide the patient a notice of non-coverage and provide care for them in accordance with our charity care policy and other financial resources. The organization invites patients and/or families to request additional assistance when they have a concern about the patient's condition. The Rapid Assessment Team can be access for both adult and pediatric patients by notifying your nurse or calling the Patient Care Coordinator by dialing 0.

Patients have a right:

1. to be treated and cared for with dignity and respect;
2. to complain about their care and treatment without fear of retribution or denial of care;
3. to be involved in all aspects of their care including:
    a. Refusing care and treatment
    b. Resolving problems with care decisions;
    c. Be informed of unanticipated outcomes;
    d. Be informed and agree to their care;
    e. Family input in care decision;
    f. Have advance directives and for the hospital to respect and follow those directives;
    g. Request no resuscitation or life-sustaining treatment;
    h. End of life care;
4. to donate organs and other tissues including:

Pain Management – Patients have the right to receive appropriate pain management.

Healthcare Information and Consent – Patients and/or legal representative have the right to receive complete information about their health status, diagnosis, treatment, and any known prognosis in terms they can easily understand. They also have the right to see their medical records within the limits of the law.

Patients have the right, to the greatest extent possible, to participate in decisions concerning their medical care, including any ethical issues that may arise. This included the right to refuse to consent to the treatment. Patients have the right to be informed of the significant risks and benefits associated with the planned treatment, to be informed of the risks and benefits of any other possible methods of treatment, and to be informed of any consequences if they refuse treatment.
Advance Directives - Patients have the right to prepare advance directives, and a durable power of attorney for healthcare, and to expect that those directives will be followed to extent permitted by law.
Communication Patients have the right to interpreter services
Continuity of Care and Caregiver Identity - Patients have the right to reasonable continuity of care and to know in advance the time and locations of appointments. Patients have the right to know the identities and responsibilities of all individuals caring for them and what services they are providing.

Safety, Respect, and Dignity –Patients have the right to a safe environment, including:

- The right to consideration and respect for personal dignity, for spiritual and cultural beliefs and practices.
- The right to be free from all forms of mental, physical, sexual, or verbal abuse, neglect, harassment or exploitation. The right to be free from physical and chemical (drug) restraints.

The right to protective and advocacy services (including but not limited to guardianship, conservatorship, adult protective or child protective services)
Privacy and Confidentiality -Patients have the right, within the law, to know that their personal privacy, including any written information about them, is protected. Those rights include:

- The right to be interviewed and examined in surroundings designed to ensure privacy from other patients, visitors, or hospital employees.
- The right to expect that any examinations, case discussions, and consultations involving their care will be conducted only with those who need to be involved.
- The right to have their medical record read only by individuals directly involved in their treatment, or in the monitoring of its quality, or by your insurance company.
- The right to expect that all communications and records pertaining to their care, including the source of payment for treatment, are treated as confidential.
- The right to request an amendment to their medical record.
- The right to request an accounting of disclosures of their health information.
- The right to request a transfer to another room if another patient or a visitor is unreasonably disturbing (transfer to another room may depend on room availability).

Pastoral Care – Patients have the right to receive pastoral care services that will respect and encourage personal, spiritual, and religious needs, values, and resources.

Complaints/Grievance – The patient has a right to a timely complaint resolution

Transfer – Patients will not be transferred to another facility or organization for care until:

- They or their legal representative have received a complete explanation of the need for the transfer and any possible alternatives,
- They or their legal representative have agreed to the transfer, and
- the physician and the facility or organization to which they will be transferred have agreed to accept them

Discharge Planning – Patients have the right to discharge planning and assistance to help get the services needed at time of discharge.
Research – Patients have the right to refuse to participate in any research project without compromising their care.
Outcome Disclosures – Patients have the right to be informed of any outcomes of care when they differ significantly from the anticipated outcomes.

Hospital Charges – Patients or their legal representative have the right to examine all charges associated with their treatment and receive an explanation of them, regardless of the method of payment.

PATIENT RESPONSIBILITIES

Provision of Information - Patients are responsible for working with doctors and the medical center staff by providing, any personal and medical history information that might be needed. They are also responsible for reporting any changes in their condition to their doctor or nurse.

Instructions and Treatment Plan - Patients are responsible for participating with their doctor in planning their treatment and recovery. They are responsible for understanding how to continue their care after discharge.
Refusal of Treatment – Patients are responsible for the results if they refuse the treatment the doctor has prescribed or if they choose not to follow the doctor's instructions, including leaving the hospital against medical advice. Parents are responsible for the results if they refuse treatment the doctor has ordered for their child. This includes leaving the hospital against the advice of your attending physician. However, if a child, any person under the age of eighteen (18) (RCW 26.44.020[6]), is admitted to this medical center for treatment and the parents and the medical staff reach a difference of opinion regarding the treatment plan, all efforts will be made to reach an agreement regarding the child's treatment. The parents or legal guardian do not have the option of removing the child from this facility against medical advice (AMA). If this is the posture of the parents, as mandated, the medical center will inform Child Protective Services (CPS). The child will remain at this facility under "Administrative Hold" (RCW 18.130; RCW 74.34.020[8]) until CPS makes a determination for safety with the medical direction of the attending physician.

Respect and Consideration - Patients are responsible for assisting the staff in providing a quiet, courteous atmosphere.

ADVOCACY PROGRAMS AVAILABLE TO PATIENTS AND THEIR FAMILIES

Patient Advocacy Program - The Patient Advocacy Program is designed to give patients an avenue to discuss any concerns they might have regarding care.

Exhibit 18
Draft Charity Care Policy

KADLEC REGIONAL MEDICAL CENTER
FINANCIAL ASSISTANCE POLICY
Section: Revenue Cycle Operations

TITLE: Financial Assistance Program	**POLICY: X** **PROCEDURE: X** **GUIDELINE: STANDARD:**	**NO.**
Key Words: aid, charity care, waived, reduced	**EFFECTIVE DATE: 01/2016**	**PAGE 1 OF 6**
ADMINISTRATIVE APPROVAL:	**SUPERSEDES:** 03/15, 03/14, 02/13, 12/12 05/12, 04/09, 8/07, 11/04, 5/02, 7/96, (203.4), 4/90, 12/85	
COMMITTEE APPROVAL/REVIEW: ET ; AUDIT & FINANCE 12/16/2015, BOARD		
DEVELOPMENT TEAM/AUTHOR(S): PFS		
AUDIT REVIEW: (By and Date) PFS 11/12, PFS 02/12, PFS 03/10, PFS 4/99; PFS 3/02		

PURPOSE:

The purpose of this policy is to set forth Kadlec Regional Medical Center's Financial Assistance and Emergency Medical Care policies, which are designed to promote access to medically necessary care for those without the ability to pay, and to offer a discount from billed charges for individuals who are able to pay for only a portion of the costs of their care. These programs apply solely with respect to emergency and other medically necessary healthcare services provided by Kadlec Regional Medical Center. This policy and the financial assistance programs described herein constitute the official Financial Assistance Policy ("FAP") and Emergency Medical Care Policy for Kadlec Regional Medical Center's hospital in Washington State.

POLICY:

Kadlec Regional Medical Center is committed to the provision of health care services to all persons in need of medical attention, and will not deny necessary health care to any individual because of his/her inability to pay, according to the policy stated herein. Persons who qualify may receive hospital services at no charge or less than routine charge. The patient is ultimately responsible to fulfill their financial obligation to Kadlec Regional Medical Center and is not granted financial assistance until the application has been completed and approved.

The Financial Assistance Program depends on Kadlec Regional Medical Center's financial ability to help patients, and does not include elective or cosmetic procedures or any services that are eligible for payment from other sources such as: Department of Social & Health Services (DSHS), Medicare, third party liability or insurance. If an individual is not currently covered by a third-party, the applicant will be screened for Medicaid, and if applicant is eligible for Medicaid an application will be completed and Medicaid will be pursued. If the applicant is not eligible for Medicaid financial assistance will be offered. Any payment sources or insurance for which the patient is eligible must be declared and assigned to the hospital before financial assistance can be made available. In the event that third party coverage[1] is discovered at a later date, any financial assistance write off will be reversed and third party insurance will be filed. If the patient would have been eligible for other third party coverage but failed to comply with the terms of that payor and payment was denied, the denied amount will not be eligible for financial assistance

1. Kadlec Regional Medical Center will comply with federal and state laws and regulations relating to emergency medical services, patient financial assistance, and charity care, including but not limited to Section 1867 of the Social Security Act, Section 501(r) of the Internal Revenue Code, RCW 70.170.060, and WAC Ch. 246-453.

2. Kadlec Regional Medical Center will provide financial assistance to qualifying patients or guarantors with no other primary payment sources to relieve them of all or some of their financial obligation for emergency and medically necessary healthcare services.

3. In alignment with its Core Values, Kadlec Regional Medical Center will provide financial assistance to qualifying patients or guarantors in a respectful, compassionate, fair, consistent, effective and efficient manner.

4. Kadlec Regional Medical Center will not discriminate on the basis of age, race, color, creed, ethnicity, religion, national origin, marital status, sex, sexual orientation, gender identity or expression, disability, veteran or military status, or any other basis prohibited by federal, state, or local law when making financial assistance determinations.

5. In extenuating circumstances, Kadlec Regional Medical Center may at its discretion approve financial assistance outside of the scope of this policy. Uncollectible/presumptive charity is approved due to but not limited to the following: social diagnosis, homelessness, bankruptcy, deceased with no estate, history of non-compliance and non-payment of account(s). All documentation must support the patient/guarantors inability to pay and why collection agency assignment would not result in resolution of the account.

6. Kadlec Regional Medical Center hospital with a dedicated emergency department will provide, without discrimination, care for emergency medical conditions within the meaning of the Emergency Medical Treatment and Labor Act (EMTALA) consistent with available capabilities,

[1] Third-Party Coverage means an obligation on the part of an insurance company, health care services contractor, health maintenance organization, group health plan, government program (Medicare, Medicaid or medical assistance programs, workers compensation, veteran benefits), tribal health benefits, or health care sharing ministry as defined in 26 U.S.C. Sec. 5000A to pay for the care of covered patients and services, and may include settlements, judgments, or awards actually received related to the negligent acts of others (for example, auto accidents or personal injuries) which have resulted in the medical condition for which the patient has received hospital health care services.

regardless of whether an individual is eligible for financial assistance. Kadlec Regional Medical Center hospital will provide emergency medical screening examinations and stabilizing treatment, or refer or transfer an individual if such transfer is appropriate in accordance with 42 C.F.R. 482.55 Kadlec Regional Medical Center prohibits any actions that would discourage individuals from seeking emergency medical care, such as by permitting debt collection activities that interfere with the provision of emergency medical care.

Providers Subject to Kadlec Regional Medical Center's FAP:

In addition to Kadlec Regional Medical Center hospital facility, all physicians and other providers rendering care to Kadlec Regional Medical Center patients during a hospital stay are subject to these policies unless specifically identified otherwise. Attachment A indicates where patients may obtain the list(s) pertaining to all Providers who render care in the Kadlec Regional Medical Center hospital departments, and whether or not they are subject to the Kadlec Regional Medical Center Financial Assistance Policy. This list can be accessed online at www.kadlec.org, and is also available in paper form by request to the Financial Counselor at the hospital.

Staff Training:

Kadlec Regional Medical Center has established a standardized training program on its Financial Assistance policy and the use of interpreter services to assist persons with limited English proficiency and non-English speaking persons in understanding information about its Financial Assistance policy.

Financial Assistance Eligibility Requirements:

Financial assistance is available for both uninsured and underinsured patients and guarantors where such assistance is consistent with federal and state laws governing permissible benefits to patients. Financial assistance is available only with respect to amounts that relate to emergency or other medically necessary services. Patients or guarantors with gross family income, adjusted for family size, at or below 350% of the Federal Poverty Level (FPL) are eligible for financial assistance, so long as no other financial resources are available and the patient or guarantor submits information necessary to confirm eligibility.

Financial assistance is secondary to all other financial resources available to the patient or guarantor, including but not limited to insurance, third party liability payors, government programs, and outside agency programs. In situations where appropriate primary payment sources are not available, patients or guarantors may apply for financial assistance based on the eligibility requirements in this policy and supporting documentation, which may include:

- Proof of application to Medicaid may be requested.

Financial assistance is granted for emergency and medically necessary services only. For Kadlec Regional Medical Center hospital, "emergency and medically necessary services" means appropriate hospital based services as defined by WAC 246-453-010(7). For Kadlec Regional Medical Center physician services these are medically necessary services provided within Kadlec Regional Medical Center hospital or in such other settings as defined by Kadlec Regional Medical Center.

Patients who reside outside the Kadlec Regional Medical Center service area where services are provided are not eligible for financial assistance, except under the following circumstances:

- The patient requires emergency services while visiting in Kadlec's service area.
- Medically necessary care provided to the patient is not available at a Kadlec facility in the service area where the patient resides.

The Kadlec Regional Medical Center service area is defined as any Washington counties serviced by the Kadlec hospital.

Eligibility for financial assistance will be determined based on the annual family income of the patient as of the time the health care services were provided, or at the time of the application for financial assistance if the application is made within two years of the time of service, the patient has been making good faith efforts towards payment of health care services rendered, and the patient demonstrates eligibility for financial assistance. At its discretion, the Kadlec Regional Medical Center may consider applications for financial assistance at any time, including any time there is a change in the patient's financial circumstances.

All income of the family as defined by Washington law governing charity care [2] is considered in determining the applicability of the Kadlec Regional Medical Center sliding fee scale in Attachment B. Patients seeking financial assistance must provide any supporting documentation specified in the application for financial assistance, unless Kadlec Regional Medical Center indicates otherwise.

Basis for Calculating Amounts Charged to Patients Eligible for Financial Assistance

Categories of available discounts and limitations on charges under this policy include:

- **100 Percent Discount/Free Care:** Any patient or guarantor whose gross family income, adjusted for family size, is at or below 300% of the current federal poverty level ("FPL") is eligible for a 100 percent discount off of total hospital charges for emergency or medically necessary care, to the extent that the patient or guarantor is not eligible for other private or public health coverage sponsorship.[3]

- **Discounts Off Charges at 75 Percent :** The Kadlec Regional Medical Center sliding fee scale set forth in Attachment B will be used to determine the amount of financial assistance to be provided in the form of a discount of 75 percent for patients or guarantors with incomes between 301% and 350% of the current federal poverty level after all funding possibilities available to the patient or guarantor have been exhausted or denied and personal financial resources and assets have been reviewed for possible funding to pay for billed charges. Financial assistance may be offered to patients or guarantors with family income in excess of 350% of the federal poverty level when circumstances indicate severe financial hardship or personal loss.

- **Limitation on Charges for all Patients Eligible for Financial Assistance**: No patient or guarantor eligible for any of the above-listed discounts will be personally responsible for more than the "Amounts Generally Billed" (AGB) percentage of gross charges, as defined in Treasury Regulation Section 1.501(r)-1(b)(2), by the

[2] "Income" and "family" are defined in WAC 246-453-010(17)-(18).
[3] *See* RCW 70.170.060 (5).

applicable Kadlec Regional Medical Center hospital for the emergency or other medically necessary services received. Kadlec Regional Medical Center determines the applicable AGB percentage for Kadlec hospital by multiplying the hospital's gross charges for any emergency or medically necessary care by a fixed percentage which is based on claims allowed under Medicare. Information sheets detailing the AGB percentages used by Kadlec Regional Medical Center's hospital, and how they are calculated, can be obtained by visiting the following website: www.kadlec.org or by calling: **1-509-942-2626** to request a paper copy. In addition, the maximum amount that may be collected in a 12 month period for emergency or medically necessary health care services to patients eligible for financial assistance is 20 percent of the patient's gross family income, provided that the patient remains eligible for financial assistance under this policy throughout the 12-month period.

Notice and Language Access:

Kadlec Regional Medical Center will display signage and information about its financial assistance policy at appropriate access areas including, but not limited to, Admissions and/or Registration areas, the Emergency Department, and Billing Services. Current versions of this policy, a plain language summary of this policy, and the Financial Assistance Application are available on Kadlec Regional Medical Center's website. The following non-English translation(s) of these are currently made available: [list available languages].

Method for Applying for Assistance and Evaluation Process:

Patients or guarantors may apply for financial assistance under this Policy by any of the following means: (1) advising Kadlec Regional Medical Center's patient financial services staff at or prior to the time of discharge that assistance is requested, and submitting an application form and any documentation if requested by Kadlec Regional Medical Center's; (2) downloading an application form from Kadlec Regional Medical Center's' website, at: www.kadlec.org, and submitting the form together with any required documentation; (3) requesting an application form by telephone, by calling: **1-509-942-2626**, and submitting the form; or (4) any other methods specified in Kadlec Regional Medical Center's Billing and Collections Policy.
The hospital will give a preliminary screening to any person applying for financial assistance. As part of this screening process Kadlec Regional Medical Center will review whether the person has exhausted or is ineligible for any third-party payment sources. Kadlec Regional Medical Center may choose to grant financial assistance based solely on an initial determination of a patient's status as an indigent person, as defined in WAC 246-453-010(4). In these cases, documentation may not be required. In all other cases, documentation is required to support an application for financial assistance. This may include proof of family size and income and assets from any source, including but not limited to: copies of recent paychecks, W-2 statements, income tax returns, forms approving or denying Medicaid or state funded medical assistance, forms approving or denying unemployment compensation, written statements from employers or welfare agencies, and/or bank statements showing activity. If adequate documentation cannot be provided, Kadlec Regional Medical Center may ask for additional information.

A patient or guarantor who may be eligible to apply for financial assistance may provide sufficient documentation to Kadlec Regional Medical Center to support an eligibility determination until fourteen (14) days after the application is made or two hundred forty (240) days after the date the first post-discharge bill was sent to the patient, whichever is later per the 501(r) regulations. Kadlec

Regional Medical Center acknowledges that per the WAC 246-453020(10), a designation can be made at any time upon learning that a party's income is below 200% of the federal poverty standard. Based upon documentation provided with the application, Kadlec Regional Medical Center will determine if additional information is required, or whether an eligibility determination can be made. The failure of a patient or guarantor to reasonably complete appropriate application procedures within the time periods specified above shall be sufficient grounds for Kadlec Regional Medical Center to determine the patient or guarantor ineligible for financial assistance and to initiate collection efforts. An initial determination of potential eligibility for financial assistance will be completed as closely as possible to the date of the application.

Kadlec Regional Medical Center will notify the patient or guarantor of a final determination of eligibility or ineligibility within ten (10) business days of receiving the necessary documentation.

The patient may appeal a determination of ineligibility for financial assistance by providing relevant additional documentation to Kadlec Regional Medical Center within thirty (30) days of receipt of the notice of denial. All appeals will be reviewed and if the determination on appeal affirms the denial, written notification will be sent to the patient and the Washington State Department of Health in accordance with state law. The final appeal process will conclude within ten (10) days of the receipt of the appeal by Kadlec Regional Medical Center. Other methods of qualifications for Financial Assistance may fall under the following:

- The legal statue of collection limitations has expired;
- The guarantor has deceased and there is no estate or probate;
- The guarantor has filed bankruptcy;
- The guarantor has provided financial records that qualify him/her for financial assistance; and/or
- Financial records indicate the guarantor's income will never improve to be able to pay the debt, for example with guarantors on lifetime fixed incomes.

Billing and Collections: Any unpaid balances owed by patients or guarantors after application of available discounts, if any, referred to collections in accordance with Kadlec Regional Medical Center's uniform billing and collections policies. For information on Kadlec Regional Medical Center's billing and collections practices for amounts owed by patients or guarantors, please see Kadlec Regional Medical Center's Billing and Collections Policy, which is available free of charge at Kadlec hospital's registration desk, at: www.kadlec.org; or which can be sent to you if you call: **1-509-942-2626.**

ATTACHMENT A
Hospital-Based Providers Not Subject to Kadlec Regional Medical Center's Financial Assistance Policy and Associated Discounts

A list is available of all Providers who render care in the Kadlec Regional Medical Center hospital, and whether or not they are subject to the Kadlec Regional Medical Center's Financial Assistance Policy. This list can be accessed online at www.kadlec.org, and is also available in paper form by request to the Financial Counselor at the hospital. If a Provider is not subject to the Financial Assistance Policy then that Provider will bill patients separately for any professional services that that provider provides during a patient's hospital stay, based on the Provider's own applicable financial assistance guidelines, if any.

ATTACHMENT B
Discounts Available under Kadlec Regional Medical Center's Financial Assistance/Charity Care Policy

The full amount of hospital charges outstanding after application of any other available sources of payment will be determined to be charity care for any patient or guarantor whose gross family income, adjusted for family size, is at or below 300% of the current federal poverty guideline level (consistent with WAC Ch. 246-453), provided that such persons are not eligible for other private or public health coverage sponsorship (see RCW 70.170.060 (5)).

For guarantors with income and resources above 101% of the FPL the PH&S sliding fee scale below applies.

In determining the applicability of the Kadlec Regional Medical Center fee scale, all income of the family as defined by WAC 246-456-010 (17-18) are taken into account. Responsible parties with family income and assets between 100% and 300% of the FPL, adjusted for family size, shall be determined to be indigent persons qualifying for charity sponsorship for the full amount of hospital charges related to appropriate hospital-based medical services that are not covered by private or public third-party sponsorship as referenced in WAC 246-453-040 (1-3).

For guarantors with income and assets above 300% of the FPL household income and assets are considered in determining the applicability of the sliding fee scale.

Assets considered for evaluation; IRAs, 403(b) accounts, and 401(k) accounts are exempt under this policy, unless the patient or guarantor is actively drawing from them. For all other assets, the first $100,000 is exempt.

Income and assets as a percentage of Federal Poverty Guideline Level	**Percent of discount (write-off) from original charges**	**Balance billed to guarantor**
100-300%	**100%**	**0%**
301-350%	**75%**	**25%**

Exhibit 19
Kadlec Patient Origin by County and Zip Code

Kadlec Regional Medical Center Acute Care Patient Origin by Discharges and Patient Days - CY2017

Zip Code	Discharges	% of Discharges	Patient Days	% of Days
99301	2,964	19.7%	10,523	17.0%
99336	1,998	13.3%	7,775	12.5%
99352	1,955	13.0%	8,083	13.0%
99354	1,400	9.3%	5,472	8.8%
99337	1,013	6.7%	4,028	6.5%
99353	906	6.0%	3,473	5.6%
99320	600	4.0%	2,450	3.9%
97838	516	3.4%	2,424	3.9%
99338	467	3.1%	1,679	2.7%
99350	333	2.2%	1,527	2.5%
97801	232	1.5%	1,349	2.2%
99344	214	1.4%	1,157	1.9%
98930	202	1.3%	965	1.6%
99326	178	1.2%	673	1.1%
99349	165	1.1%	741	1.2%
97882	155	1.0%	814	1.3%
99362	139	0.9%	802	1.3%
99323	133	0.9%	468	0.8%
98944	129	0.9%	789	1.3%
99302	108	0.7%	501	0.8%
97844	105	0.7%	543	0.9%
All Other Zip Codes <100 Discharges	1,155	7.7%	5,809	9.4%
Total	**15,067**	**100.0%**	**62,045**	**100.0%**

*Excludes Neonates (DRGs 789-795), Psych (MDC 19) and Rehab (DRGs 945 and 946)

**Excludes Rehabilitation Unit utilization

Source: CHARS 2017

Kadlec Regional Medical Center Acute Care Patient Origin by Discharges and Patient Days - CY2017

County	Discharges	% of Discharges	Patient Days	% of Days
Benton	8,700	57.7%	34,612	55.8%
Franklin	3,374	22.4%	12,148	19.6%
Out-of-State	1,529	10.1%	7,900	12.7%
Yakima	480	3.2%	2,427	3.9%
Walla Walla	339	2.2%	1,608	2.6%
Grant	256	1.7%	1,233	2.0%
Adams	230	1.5%	1,228	2.0%
Columbia	45	0.3%	284	0.5%
King	19	0.1%	53	0.1%
Klickitat	13	0.1%	61	0.1%
Snohomish	12	0.1%	65	0.1%
Spokane	10	0.1%	63	0.1%
Pierce	9	0.1%	24	0.0%
Douglas	6	0.0%	116	0.2%
Chelan	5	0.0%	45	0.1%
Kitsap	5	0.0%	21	0.0%
Thurston	5	0.0%	10	0.0%
Okanogan	4	0.0%	46	0.1%
Whatcom	4	0.0%	9	0.0%
Whitman	4	0.0%	19	0.0%
Asotin	3	0.0%	9	0.0%
Clark	3	0.0%	12	0.0%
Kittitas	3	0.0%	5	0.0%
Lincoln	3	0.0%	28	0.0%
Cowlitz	2	0.0%	11	0.0%
Grays Harbor	2	0.0%	5	0.0%
Clallam	1	0.0%	2	0.0%
Garfield	1	0.0%	1	0.0%
Total	**15,067**	**100.0%**	**62,045**	**100.0%**

*Excludes Neonates (DRGs 789-795), Psych (MDC 19) and Rehab (DRGs 945 and 946)

**Excludes Rehabilitation Unit utilization

Source: CHARS 2017

Exhibit 20
Letter of Reasonableness – Equipment and Construction Estimate

Providence Health & Services
4400 NE Halsey St. Building 2, Suite 190
Portland, OR 97213
t: 503.215.3188
www.providence.org/oregon

Providence St. Joseph Health

Real Estate and Construction

July 10, 2018

Janis Sigman, Manager
Certificate of Need Program
State Department of Health
111 Israel Rd. S.E.
Tumwater, WA 98501

RE: Kadlec Regional Medical Center, Certificate of Need Application to add 67 acute care beds to its existing hospital in Richland, Benton County.

Dear Ms. Sigman:

On behalf of Providence St. Joseph Health, I am writing regarding the certificate of need application to add 67 acute care beds to Kadlec's existing hospital in Richland, Benton County. Based on our experience with similar construction projects, we have developed the following capital costs estimate.

Construction Costs	$150,000
Moveable Equipment	$1,153,959
WA Sales Tax	$112,141
Total	$1,416,100

Based on our experience, we believe the estimates are reasonable. Please contact us if you have any questions or require additional information.

Sincerely,

Alexander M. Herr, Senior Regional Director
Real Estate & Construction

Exhibit 21
Letter of Financial Commitment

August 7, 2018

Janis Sigman, Manager
Certificate of Need Program
State Department of Health
111 Israel Rd. S.E.
Tumwater, WA 98501

RE: Kadlec Regional Medical Center, Certificate of Need Application for 67 Acute Care Bed Expansion in Richland, Benton County, $1,416,100 Estimated Capital Expenditure

Dear Ms. Sigman:

Please accept this letter as evidence of financial support for Kadlec Regional Medical Center ("Kadlec") for its certificate of need application.

Kadlec, through Western HealthConnect, is pleased to commit from its corporate reserves for funding the estimated capital expenditures required for the proposed addition of 67 beds. Kadlec has sufficient cash reserves to fund the capital expenditure requirements borne by Kadlec.

Sincerely,

Helen Andrus
Chief Financial Officer, Washington & Montana Region
Providence Health & Services

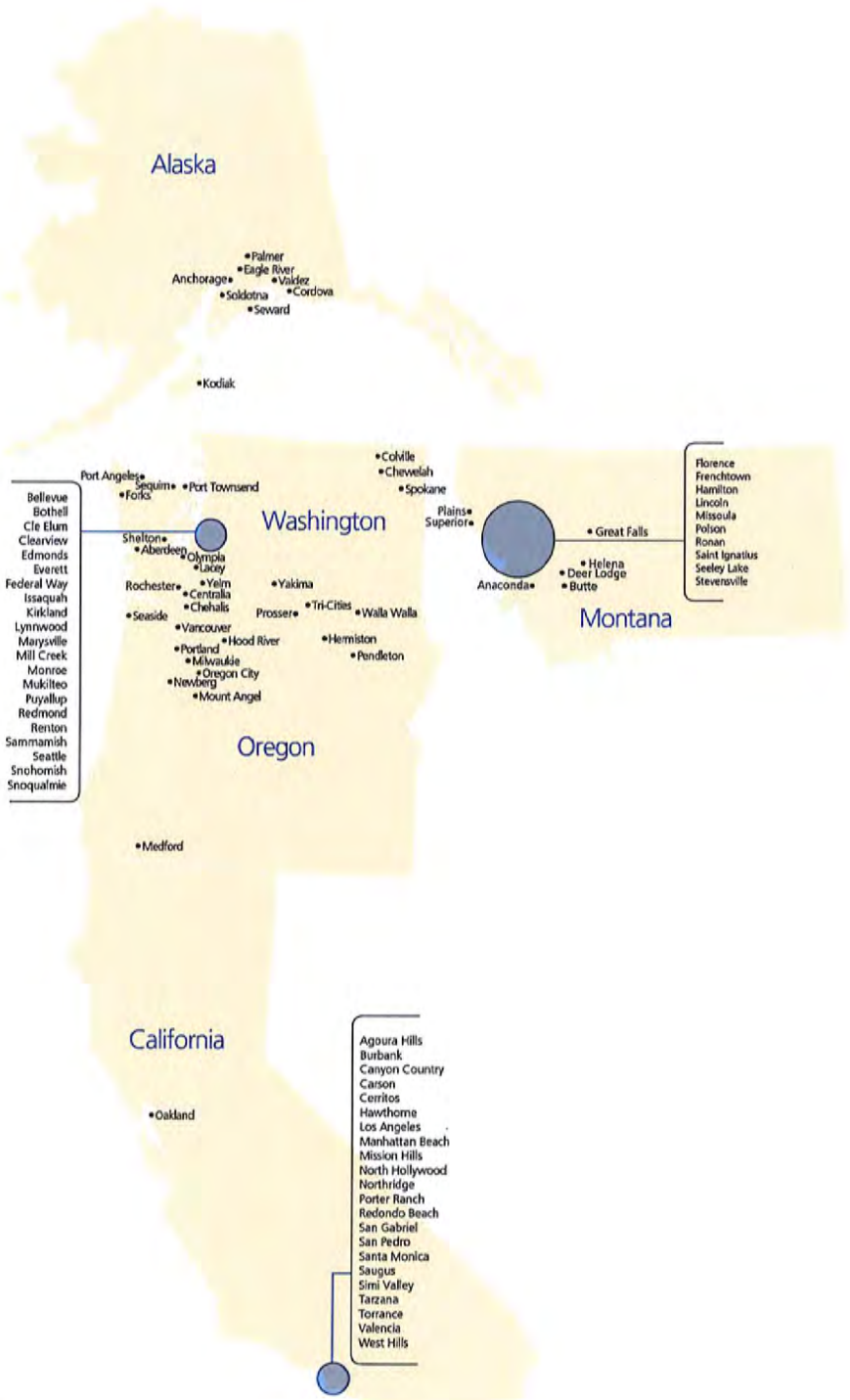
Exhibit 22
Providence Health & Services Audited Financial Statements, 2015
&
Providence St. Joseph Health Audited Financial Statements, 2016-2017

PROVIDENCE
Health & Services

Management's Discussion and Analysis of Financial Condition and Results of Operations

Year ended December 31, 2015

Todd Hofheins, Executive Vice President and Chief Financial Officer



The care and services Providence delivers spans from birth to hospice, to care for the whole person. Our comprehensive scope of services includes acute care, physician clinics, long term and assisted living, palliative and hospice care, home health, education and supportive housing. Our ministries are in Alaska, California, Montana, Oregon and Washington with our system office located in Renton, Washington.

PROVIDENCE
Health & Services

Introduction to Management's Discussion and Analysis

Management's discussion and analysis provides additional narrative explanation of the financial condition, operational results and cash flow of Providence Health & Services (Providence) to increase understanding of the health system's combined financial statements. The discussion and analysis should be read in conjunction with the accompanying audited combined financial statements.

Creating healthier communities, together

As health care evolves, Providence is responding with a vision and core strategy to transform and innovate at scale. Across five states, Providence and its affiliates continue to pioneer how care is delivered by sharing one strategic plan designed to improve the health of entire populations by supporting the well-being of each person we serve. Our core strategy of "*Creating healthier communities, together*" is supported by five specific areas of focus in our strategic plan:

- Inspire: We must first inspire and develop our people.
- Know: To serve our communities effectively, we are building enduring relationships with consumers.
- Partner: Providing the best care requires new alignments with clinicians and care teams.
- Adapt: We'll develop and thrive under new care delivery and economic models.
- Adopt: To serve more people we will grow by optimizing expert-to-expert capabilities.

This plan supports our vision, "Together, we answer the call of every person we serve: Know me, care for me, ease my way ®," which is our promise to our patients, customers and communities. Through innovation, excellence, good stewardship and working together across Providence, we will continue to lead change to improve the health of our communities.

Investing in our communities to improve health and increase access

With strong support from Providence, Alaska launched Medicaid expansion in 2015 and Montana began expansion early in 2016, ensuring that all five of our states have increased eligibility under the Affordable Care Act. In an environment of decreased reimbursement for government-sponsored medical care, community benefit spending related to the unpaid costs of Medicaid was $538 million in 2015 compared with $444 million in 2014. Providence cares for everyone, regardless of their ability to pay. In 2015 we provided more than $951 million in community benefit, which increased over $100 million from 2014.

Providence had a strong impact on landmark new payment codes that recognize the value of advance care planning by reimbursing clinicians for having these discussions with their patients. The Centers for Medicare and Medicaid Services adopted recommendations developed by Providence and our partners that advance care planning be added as an optional, separately billable, element of the annual wellness visit. Going into effect in 2016, these codes will be instrumental for Providence, other Catholic ministries, and other providers that are committed to whole-person care models.

Together, we answer the call of every person we serve: Know me, care for me, ease my way.

Collaborating with like-minded partners

St. Joseph Health System

Providence and St. Joseph Health continue to work through the process of bringing our organizations together after signing a letter of intent in July 2015 and a definitive agreement in November 2015 to create a new single organization. Closure of the transaction is dependent on the timing of regulatory review, which we now estimate will be complete in the second quarter of 2016.

The two Catholic health systems, with long histories of serving communities in the American West, plan to create a new parent organization, Providence St. Joseph Health, that will focus on a shared mission and vision, as well as the strategic, financial and operational direction for the system overall. Dr. Rod Hochman will serve as the CEO of the parent organization, which will be based in Renton, Wash. There will be two system offices - in Renton and in Irvine, Calif. The board of directors of the parent organization will include seven members appointed by Providence and seven members appointed by St. Joseph Health.

> *"Together, we can invest more in the needs of everyone we serve, especially the most vulnerable,"*
> ***-Rod Hochman, M.D., President and CEO***

Walgreens

As part of our commitment to creating healthier communities together, Providence is collaborating with Walgreens to open 25 clinics in Walgreens stores in Oregon and Washington during the next two years, starting with six clinics in Portland and Seattle opening in February 2016. In Portland, the clinics will be operated by Providence, staffed by Providence providers, and called Providence Express Care at Walgreens and in the Seattle area will be operated by Swedish, staffed by Swedish providers, and called Swedish Express Care at Walgreens. This program is another way we are answering the call of every person we serve. Current patients will experience a seamless patient experience through our existing electronic health record system, providing direct connectivity to the clinics and billing systems which will ensure better continuity of patient care and collaboration among providers.

Greater Fairbanks Community Hospital Foundation

Providence has signed a letter of intent with the Greater Fairbanks Community Hospital Foundation to pursue a lease agreement under the secular entity Western HealthConnect. The agreement would cover operations for Fairbanks Memorial Hospital, Denali Center and Tanana Valley Clinic. Fairbanks Memorial Hospital has 152 licensed beds and has served the community for more than 40 years.

The Hospital Foundation began a search for a new lease agreement partner after deciding not to renew a 15-year affiliation with Arizona-based Banner Health. Providence is honored to be selected as their proposed new partner and look forward to working with the Hospital Foundation to create healthier communities, together. We are excited to continue this tradition and to return to the Fairbanks community, where we served from 1910 to 1968.

As part of the letter of intent, we will negotiate a transition lease - under essentially the same terms as Banner - with the intent to negotiate a multi-year lease in the future. The lease agreement will be with Western HealthConnect, the entity formed to allow Providence to remain Catholic and secular affiliates to

remain secular. This is the same model we used for our affiliations with Swedish, Pacific Medical Centers and Kadlec.

Leading dynamic change through innovation

Population Health

Population health will be a critical part of achieving Providence's strategy of creating healthier communities, together. Our goal is to maximize the health outcomes of the people in our defined populations and communities through the design, delivery and coordination of affordable quality health care. We are focused on the customer experience, while driving operational and financial excellence though our innovation in this space.

Consumer Health Engagement and Support

Our innovation team is developing tools and services that engage consumers to keep them healthy between episodes of care. For example, we will test a new service line for our 65 and over population that aims to increase the options seniors have in the choice to safely age in place in their homes and defer the stress and costs of a move to a long term care facility. The program will partner with our clinics to support day to day living tasks like meal delivery and transportation, improve the safety of a senior's home, and provide trusted planning and advice about aging optimally.

Leadership in the Healthcare Industry

Rod Hochman, M.D., president and chief executive officer, was recently appointed to the Board of Trustees for the Catholic Health Association of America.

Mike Butler, president, operations and services, has joined the Board of Directors of Medical Teams International.

Amy Compton-Phillips, M.D., executive vice president and chief clinical officer, along with **Rhonda Medows**, M.D., executive vice president of population health, were recently listed in Becker's Hospital Review annual list of influential female leaders in health care.

Providence ExpressCare

In order to provide health care to our patients on their own terms through a diverse range of care delivery offerings, Providence has launched ExpressCare, where patients can receive primary care in a retail setting. In addition to twenty-five ExpressCare Walgreens-embedded clinics, twenty-five standalone retail clinics will be opening throughout Washington, Oregon, California, and Montana in 2016 and 2017. ExpressCare clinics will be equipped with in-clinic "Appointments Now Available" monitors, website registration and scheduling, as well as walk-in kiosks with scheduling, check-in, and registration. ExpressCare will also be supported by a mobile app with clinic search, scheduling, registration and MyChart access as well as integrated telehealth.

Telehealth

Significant progress was made on our 2015 priorities including: iterating on and rolling out a new B2B technical infrastructure, turning on self-service features, accelerating deployment velocity and efficiency, and developing capabilities to be able to deploy easily to new service lines. We have developed a fully integrated platform that will effectively support both expert-to-expert telehealth as well as direct to consumer telehealth. Priorities for 2015 included improving quality of communication for clinicians and

patients, reduced cost and accelerated deployment, safe and easy self-service features, and developing capabilities to be able to deploy easily to new service lines. The expert-to-expert telehealth platform for Telestroke was launched in 43 locations, while the Telehospitalist program completed a successful pilot and is now being deployed more broadly. HealthExpress, our $39 urgent care telehealth offering is now available in Washington and Oregon. Visit http://healthexpress.com to learn more.

Providence Milestones

- Named as one of the 'Most Wired' organizations in health care by the American Hospital Association.
- Ranked 153 of 500 on the Forbes list of America's Best Employers in 2015.
- The power of our Mission continues to shine through in a recent survey with 92 percent of caregivers (all employees) agreeing with the statement, "My work supports the Mission."

Financial Performance

Year-end Results

Key Financial Indicators *Data is year-to-date; dollar figures presented in millions*	2015	2014	Organic Growth*
Net Operating Income	$262	$219	$233
Net Income	$77	$771	$44
EBIDA	$864	$1,133	$807
Total Community Benefit	$951	$848	$931
Operating Margin %	1.8%	1.8%	1.7%
Accounts Receivable Days	47	50	48
Days of Cash on Hand	159	183	163
Long-term Debt to Total Capitalization	33.8%	33.8%	33.3%
Cash to Debt	138.1%	130.9%	148.2%

** Reflects 2015 year-to-date results from entities that have been affiliated with Providence for more than 12 months.*

Operating income increased by 19.5 percent over the prior year, growing from $219 million in 2014 to $262 million in 2015. Operating margin remained consistent with the prior year at 1.8 percent while revenues continued to increase in 2015. Total net service revenue grew 16.7 percent or $1.7 billion over the prior year from $10.1 billion in 2014 to $11.8 billion in 2015 driven by higher volumes and the recognition of revenue from state provider tax programs.

While operating income experienced positive growth in 2015, annual investment performance had a negative impact on Providence's net income and earnings before interest, depreciation, amortization and affiliation gains (EBIDA) as a result of challenging market conditions. Total investment losses for the year were $114 million as compared to $178 million in positive investment income in 2014. As a result, net income for the twelve months ended December 31, 2015 was $77 million as compared to $771 million in the prior year. Net non-operating income, excluding investment income, was -$71 million in 2015 compared to $374 million in 2014. The 2015 non-operating income was primarily impacted by pension settlement costs, while 2014 was benefited from affiliation related gains, partially offset by extinguishment of debt and pension settlement costs. EBIDA was $864 million in 2015 as compared to $1,133 million in 2014.

Several of the states we serve operate broad-based provider tax programs to fund the non-federal share of Medicaid. Providence recorded net operating income of $84 million during the twelve months of 2015 related to these programs, compared to no related revenue in the prior year. Timing of program approval by regulating agencies can impact the timing of recognizing related income, and as a result, approximately $50 million of the provider tax income recorded in 2015 related to services provided in 2014.

Liquidity & Capital

Unrestricted cash reserves totaled $5.8 billion as of December 31, 2015 compared to $6.0 billion as of December 31, 2014. The decrease was primarily driven by investment losses, capital purchases, and debt payments made during the year, partially offset by cash generated from operations.

Days cash on hand (DCOH) decreased 24 days from 183 days on December 31, 2014 to 159 days on December 31, 2015. This decline was driven by a combination of factors. First, a reduction in cash reserves primarily driven by investment losses. Second, patient volume growth led to higher operating revenues and corresponding expenses year over year.

Volumes

Key Volume Indicators *Data is year-to-date; presented in thousands unless noted*	2015	2014	Organic Growth*
Inpatient Admissions	362	333	353
Acute Adjusted Admissions	651	602	633
Total Emergency Room Visits	1,457	1,332	1,411
Total Surgeries	244	227	238
Continuum Services Visits	2,319	2,272	2,319
Physician Care Visits	7,742	6,881	7,443
Connected Lives - Member Months	6,050	5,147	6,050
Observations	56	58	56
Rate - Net Service Revenue/CMAA (whole value)	$12,295	$11,499	$12,299
CMI Adjusted Length of Stay (whole value)	2.9	2.9	2.9

** Reflects 2015 year-to-date results from entities that have been affiliated with Providence for more than 12 months.*

Providence's continued investment in our communities and strategy of collaborating with like-minded partners led to higher acute setting volumes in 2015. Year-to-date inpatient admissions of 362 thousand were 29 thousand or 8.7 percent higher than the prior year. Year-to-date surgeries of 244 thousand were 17 thousand higher than prior year, which represented a 7.3 percent increase. Surgery counts increased in both inpatient and outpatient categories with inpatient increasing 8.7 percent and outpatient increasing 6.1 percent in 2015 as compared to 2014. Emergency visits were 125 thousand visits or 9.4 percent higher in 2015.

Strategic focus and innovations in clinical and home based care led to growth in these categories in 2015. Physician visits of 7,742 thousand were 861 thousand visits higher than the prior year, an increase of 12.5

percent. Continuum services, which include long term care, hospice, housing, assisted living and home health, generated 2,319 thousand visits year-to-date, which was 2.1 percent higher than the prior year.

The Providence Health Plan has continued to expand its services in the changing coverage landscape. Connected lives member months, a measure of coverage for insured members, increased from 5,147 member months in 2014 to 6,050 member months in 2015. This growth in member coverage represented a 17.5 percent increase compared to the prior year. Enrolled members, including Administrative Services Only (ASO) members, grew 17 percent from 437 thousand in December 2014 to 513 thousand in December 2015.

Revenue

Operating Revenue *Data is year-to-date, figures presented in millions*	2015	2014	Organic Growth*
IP Net Service Revenue	$ 6,386	5,306	6,235
OP Net Service Revenue	3,381	3,145	3,252
Primary Care	1,486	1,232	1,465
Continuum Services	715	612	715
Capitated & Premium Revenue	1,862	1,683	1,814
Bad Debt	(186)	(193)	(179)
Other Revenue	790	696	781
Total Operating Revenue	**$ 14,434**	**12,481**	**14,083**

** Reflects 2015 year-to-date results from entities that have been affiliated with Providence for more than 12 months.*

Year-to-date operating revenue of $14.4 billion was $2.0 billion or 15.6 percent greater than prior year. Revenue included $612 million from provider tax related programs, of which $240 million was related to the prior year. Payments related to 2014 were recorded in 2015 due to the timing of program approvals from state agencies that administer the provider fee programs. Capitated revenue of $399 million was 17.6 percent higher than the prior year as a result of growth in our accountable care organizations. Total premium revenue of $1,464 million was 8.9 percent higher as membership in the Providence Health Plans expanded in 2015. Premium revenue grew at a slower rate than enrollments primarily due to a change in product mix from 2014 to 2015, which saw a general shift towards more high deductible plans. Capitated and premium revenue represented 13 percent of Providence's total operating revenue, in line with the prior year.

Since 2012 Providence has participated in federal programs designed to provide incentive funding to hospitals and providers that implement electronic health record systems. Providence recorded $22 million in revenue in 2015 related to this meaningful use funding, which was lower than the $55 million recorded in 2014. This year-over-year decrease was expected as most providers and hospitals near the end of the three year incentive program.

Operating Expenses

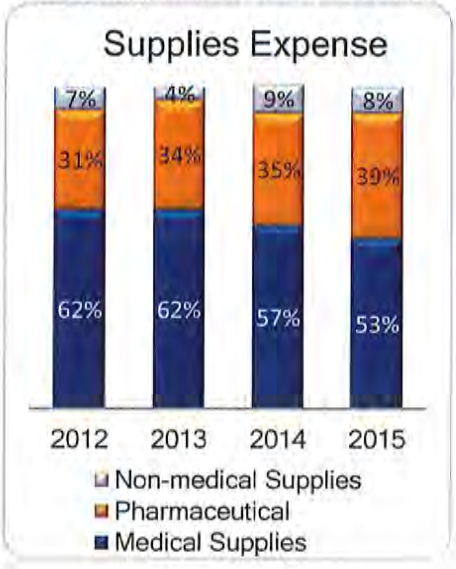
Key Efficiency Indicators *Data is year-to-date*	2015	2014	Organic Growth*
FTEs (presented in thousands)	70.4	65.4	67.1
Productivity - Labor % Net Service Rev.	50.8%	52.0%	50.9%
Supplies % Net Service Revenue	17.6%	17.7%	17.5%
Efficiency - Expense/CMAA	$ 12,040	$ 11,270	$ 12,070

** Reflects 2015 year-to-date results from entities that have been affiliated with Providence for more than 12 months.*

Year-to-date operating expenses were 15.6 percent higher than the prior year, which followed the 15.6 increase in operating revenue. Fees from provider tax related programs were $528 million in 2015 while no related expenses were recorded in 2014. Timing of program approval by regulating agencies resulted in all 2014 related expenses totaling $190 million being recorded in 2015. Expense growth was correlated with the higher patient volumes experienced in 2015. After removing the impact of provider fee taxes, growth of salary expenses and supply expenses outpaced operating expenses on a percentage basis, while benefits expenses and depreciation grew at a slower pace.

Year-to-date labor expense, defined as the combination of salaries and wages, employee benefits, and purchased services, was $1.0 billion or 13.4 percent higher than the prior year. Full-time equivalents (FTEs) of 70.4 thousand increased 7.6 percent, which represented an increase of 5.0 thousand FTEs. Labor expense growth outpaced FTEs in part due to high utilization of agency labor in 2015 to staff open positions. Agency labor increased 69 million or 42.3 percent in 2015 compared to the prior year. Higher salary expense was also a reflection of strategic investments made to move Providence to an institutes model of management. Total salary expense increased 14.0 percent while total benefits expense increased 11.3 percent compared to the prior year. Per member per month (PMPM) employee medical costs in 2015 were 3.8 percent higher over the prior year in part due to higher pharmaceutical costs.

Supply expenses increased $279 million or 15.6 percent compared to the prior year, but decreased slightly as a percentage of total net service revenue from 17.7 percent in 2014 to 17.6 percent in 2015. Medical supply expenses, a component of total supply expenses, increased 8.7 percent compared to the prior year which was in line with the growth in volume increases. Pharmaceutical expenses, the other significant component of supply expense, increased 30.4 percent compared to the prior year. Just under a third of the increase was volume driven with the remainder a result of price increases. Ten drugs accounted for 33 percent of the year-over-year price inflation from wholesaler drug purchases. Particularly high inflation was experienced among sole-source generic drugs and specialty pharmaceuticals. Market forces continue to move toward consolidation of generic drug producers, leading to significant price increases. In 2015 half of drugs purchased by Providence were branded drugs for which we have no ability to negotiate discounted rates. Continued consolidations of generic



drug producers is reducing the availability of options in the generics market by converting low cost generics to sole source branded suppliers.

Non-operating Income

Non-operating gains and losses are primarily comprised of investment income, pension settlement costs, and innovation projects expense. Pension settlement costs and innovation expenses were $34 million and $27 million through December, respectively. The remaining balance of non-operating income was driven by investment losses for the year, which were $114 million as compared to $178 million in positive investment income in 2014.

Investment Performance

Allocation by Asset Class *(Dollar figures presented in millions)*	Providence 12/31/15 Balance	Percent Allocation	Annual Return
Equities	$1,314	23%	$(54)
Fixed income	2,231	38%	2
Alternative Investments	861	15%	(66)
Cash & Other	1,396	24%	4
Total	**$5,802**	**100%**	**$(114)**

Within our portfolio, we saw growth hedge funds and our public and private debt positions outperform their respective indices for the year. Assets underperformed largely due to current allocations to Master Limited Partnerships (MLPs), Risk Parity and Commodities.

On a year-to-date basis, consolidated asset investments returned -3.22 percent, compared to the policy benchmark return of -2.54 percent. On a relative basis, our public equity pool returned -4.72 percent, driven by severe underperformance in Risk Parity, compared to the MSCI AC World IMI index return of -2.19 percent. Fixed income assets for the year returned 0.95 percent compared to the Barclays US Aggregate Index annual return of 0.55 percent; and our Alternative Investments returned 1.48 percent compared to our Alternative Investment Composite benchmark return of 1.03 percent.

Credit Agency Ratings

Providence received affirmation on the following ratings from the three national credit rating agencies during the latest round of reviews in June and July.

- Fitch: "AA"
- Standard and Poor's: "AA-"
- Moody's: "Aa3"

Ratings from all three agencies remained unchanged from the prior year, and all agencies issued a stable outlook based on improved year-over-year operating performance and stable balance sheet measures.

Debt Supported by Self-Liquidity

PH&S has authorized $200 million in taxable commercial paper that is supported by self-liquidity. As of December 31, 2015, $125 million in commercial paper was outstanding.

The System reports monthly on its cash and investment balances available to retire maturing short-term debt in the event notes cannot be remarketed. The table below summarizes the information provided to the rating agencies at the end of the fourth quarter describing cash and investments that could be available for liquidation.

Standard & Poor's Liquidity Assessment Coverage Calculation Spreadsheet (Last Revised January 2010)

INSTRUCTIONS: Fill in Green Cells to Compute Coverage Amounts

Liquidity Assessment Provider Name: Providence Health & Services
Portfolio As of Date: December 31, 2015

Asset Allocation (Security Type)	Assets ($ millions) with same day liquidity (T+0)	Assets ($ millions) with next day liquidity (T+1)	Assets ($ millions) with > same day liquidity (T+2, T+3,...T+n)	$ in Millions	Discount Factor	Discounted Assets
Cash & Cash Equivalents *	$ 524.03	$ -	$ -	$ 524.03	1.00	$ 524.03
S&P rated money market funds (> Am)	$ 206.41	$ -	$ -	$ 206.41	1.00	$ 206.41
Highly rated (A-1 or A-1+) dedicated bank line	$ -	$ -	$ -	$ -	1.00	$ -
Highly rated (A-1 or A-1+) money market instruments (< 1yr)	$ -	$ 4.01	$ -	$ 4.01	0.91	$ 3.64
U.S. Treasury Debt Obligations (> 1 year)	$ -	$ 304.34	$ -	$ 304.34	0.91	$ 276.67
U.S. TIPs	$ -	$ 94.25	$ -	$ 94.25	0.87	$ 81.95
U.S. Agencies (> 1 year)	$ -	$ 95.97	$ -	$ 95.97	0.83	$ 79.97
Investment Grade Debt (that is not included above)	$ -	$ -	$ 229.16	$ 229.16	0.67	$ 152.78
Equities**	$ -	$ -	$ 393.41	$ 393.41	0.50	$ 196.71
Non-Investment Grade Debt	$ -	$ -	$ 6.87	$ 6.87	0.40	$ 2.75
Total	$ 730.44	$ 498.56	$ 629.45	$ 1,858.44		$ 1,524.91
Discounted Total	$ 730.44	$ 442.24	$ 352.23			Discounted Total

	Enter amount of Self Liquidity Backed Debt with:		
	Same Day Notice	Next Day Notice	> Next Day Notice
Commercial Paper		$ 100.00	$ 100.00
Variable Rate Demand Note or Obligation	$ -		$ -
Fixed Rate Debt			
Other Securities			
Total	$ -	$ 100.00	$ 100.00
Remaining Discounted Assets	$ 730.44	$ 1,072.68	$ 1,324.91
	Same Day +/-	Next Day +/-	> Next Day +/-
	Sufficient	Sufficient	Sufficient

TOTAL DEBT SUPPORTED BY SELF LIQUIDITY	TOTAL REMAINING DISCOUNTED ASSETS
$ 200.00	$ 1,324.91

Performance Metrics	December 31, 2015		
	Year-To-Date Actual	Year-To-Date Budget	Year-To-Date Last Year
Volume:			
Acute Adjusted Admissions	651,198	630,518	602,468
Total Acute Admissions	361,689	352,410	333,263
Total Acute Patient Days	1,630,317	1,561,749	1,495,451
Acute Outpatient Visits	8,484,580	8,297,727	8,005,170
Observations	56,353	58,908	57,965
Primary Care Visits	7,741,961	7,789,622	6,881,113
Long-Term Care Patient Days	410,672	420,836	411,517
Home Health Visits	697,040	679,430	667,708
Hospice Days	642,506	663,325	628,182
Housing and Assisted Living Days	568,913	525,451	564,110
Health Plan Members	513,113	461,681	436,930
Total Occupancy %	64.8%	62.4%	59.5%
Total Average Daily Census	4,467	4,279	4,097
Surgeries:			
Inpatient	115,639	112,853	106,414
Outpatient	128,263	119,803	120,890
Total Surgeries	243,902	232,656	227,304
Emergency Room Visits:			
Inpatient	195,313	189,860	179,129
Outpatient	1,261,493	1,176,269	1,152,536
Total Emergency visits	1,456,806	1,366,129	1,331,665
Outpatient Visits:			
Outpatient Surgery	128,263	119,803	120,890
Emergency Visits	1,261,493	1,176,269	1,152,536
Primary Care	7,741,961	7,789,622	6,881,113
Homecare Visits	697,040	679,430	667,708
Observations	56,353	58,908	57,965
All Other	7,038,471	6,942,748	6,673,778
Total Outpatient Visits	16,923,581	16,766,780	15,553,990

Performance Metrics	December 31, 2015		
	Year-To-Date Actual	Year-To-Date Budget	Year-To-Date Last Year
Efficiency:			
FTE's	70,438	69,328	65,369
YTD Overall Case-Mix Index	1.5738	1.5635	1.5699
YTD Case-Mix Adj Admissions (CMAA)	1,024,874	985,840	945,794
YTD Acute Care LOS (case-mix adj)	2.9	2.8	2.9
YTD Net Svc Rev/CMAA	12,295	11,931	11,499
YTD Net Expense/CMAA	12,040	11,727	11,270
YTD Paid Hours/CMAA	143	146	140
YTD Productive Hours/CMAA	127	130	124
FTE's Per Adjusted Occupied Bed	8.76	9.06	8.62
Financial Performance:			
Operating Margin	1.8%	1.5%	1.8%
Total Margin	0.5%	3.5%	5.9%
EBIDA ('000)	864,158	1,341,871	1,132,694
EBIDA Margin	6.0%	9.9%	5.7%
R12 Days of Total Cash on Hand	159	156	183
Net Patient AR Days (3 mo rolling ave)	47	63	50
Ave Yearly Salary/FTE (w/o benefits)	84,950	83,353	82,171
Employee Benefits as a % of Salaries	22.7%	23.9%	23.2%
Salary Wages as a % of Net Op Rev	41.5%	42.5%	42.0%
Supplies as a % of Net Op Revenue	14.4%	13.7%	14.4%
YTD Supplies Expense/CMAA	2,022	1,886	1,895
YTD Med Supplies Exp/CMAA	1,077	1,045	1,073
Debt to Total Net Asset Ratio	33.8	30.6	33.8
Cash to Debt Ratio	138.1	131.4	130.9
Current Ratio	1.4	1.8	1.5
Bad Debt & Charity % Gross Svc Rev	2.2%	3.0%	2.8%
Community Benefit: ('000)			
Cost of Charity Care Provided	$ 180,256	$ 215,219	$ 205,555
Medicaid Charity	537,894	460,180	443,622
Education and Research Programs	112,826	79,288	96,988
Unpaid Cost of Other Govt Programs	47	1,088	1,157
Negative Margin Services and Other	68,095	61,507	57,355
Non-Billed Services	52,206	26,025	43,806
Total Community Benefit	$ 951,324	$ 843,307	$ 848,483

PROVIDENCE HEALTH & SERVICES

Combined Financial Statements

December 31, 2015 and 2014

(With Independent Auditors' Report Thereon)

KPMG LLP
Suite 2900
1918 Eighth Avenue
Seattle, WA 98101

Independent Auditors' Report

The Board of Directors
Providence Health & Services:

We have audited the accompanying combined financial statements of Providence Health & Services, which comprise the combined balance sheets as of December 31, 2015 and 2014, and the related combined statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the combined financial statements.

Management's Responsibility for the Combined Financial Statements

Management is responsible for the preparation and fair presentation of these combined financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of combined financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these combined financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the combined financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the combined financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the combined financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the combined financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the combined financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the combined financial statements referred to above present fairly in all material respects, the financial position of Providence Health & Services as of December 31, 2015 and 2014, and the results of their operations and their cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

Other Matter

Our audits were conducted for the purpose of forming an opinion on the combined financial statements as a whole. The supplemental information, included on pages 38 and 39 is presented for the purpose of additional analysis and is not a required part of the combined financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the combined financial statements. The information has been subjected to the auditing procedures applied in the audit of the combined financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the combined financial statements or to the combined financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the combined financial statements as a whole.

KPMG LLP

Seattle, Washington
March 9, 2016

PROVIDENCE HEALTH & SERVICES

Combined Balance Sheets

December 31, 2015 and 2014

(In thousands of dollars)

Assets		2015	2014
Current assets:			
Cash and cash equivalents	$	729,321	1,237,337
Short-term management-designated investments		200,251	199,338
Accounts receivable, less allowance for bad debts of $343,835 in 2015 and $289,908 in 2014		1,569,827	1,419,495
Other receivables, net		399,291	375,185
Supplies inventory		194,619	185,821
Other current assets		140,836	203,337
Current portion of funds held by trustee		54,740	76,365
Total current assets		3,288,885	3,696,878
Assets whose use is limited:			
Management-designated cash and investments		4,930,858	4,601,153
Gift annuities, trusts, and other		93,804	53,954
Funds held by trustee		272,902	179,473
Assets whose use is limited, net of current portion		5,297,564	4,834,580
Property, plant, and equipment, net		6,580,860	6,622,566
Other assets		572,968	568,884
Total assets	$	15,740,277	15,722,908

See accompanying notes to combined financial statements.

(Continued)

PROVIDENCE HEALTH & SERVICES

Combined Balance Sheets

December 31, 2015 and 2014

(In thousands of dollars)

Liabilities and Net Assets		2015	2014
Current liabilities:			
Current portion of long-term debt	$	244,532	202,287
Master trust debt classified as short-term		137,500	12,500
Accounts payable		427,567	521,942
Accrued compensation		641,406	738,075
Payable to contractual agencies		104,651	151,778
Retirement plan obligations		190,278	185,517
Current portion of self-insurance liability		118,898	108,943
Other current liabilities		463,198	465,865
Total current liabilities		2,328,030	2,386,907
Long-term debt, net of current portion		3,729,795	3,844,262
Other long-term liabilities:			
Self-insurance liability, net of current portion		292,843	274,541
Pension benefit obligation		1,063,581	1,040,939
Other liabilities		290,380	227,099
Total other long-term liabilities		1,646,804	1,542,579
Total liabilities		7,704,629	7,773,748
Net assets:			
Unrestricted:			
Controlling interest		7,541,875	7,492,324
Noncontrolling interest		44,904	45,302
Temporarily restricted		324,891	305,277
Permanently restricted		123,978	106,257
Total net assets		8,035,648	7,949,160
Total liabilities and net assets	$	15,740,277	15,722,908

See accompanying notes to combined financial statements.

PROVIDENCE HEALTH & SERVICES

Combined Statements of Operations

Years ended December 31, 2015 and 2014

(In thousands of dollars)

	2015	2014
Operating revenues:		
Net patient service revenues	$ 11,969,116	10,294,637
Provision for bad debts	(185,567)	(193,018)
Net patient service revenues less provision for bad debts	11,783,549	10,101,619
Premium and capitation revenues	1,862,236	1,682,968
Other revenues	787,996	696,390
Total operating revenues	14,433,781	12,480,977
Operating expenses:		
Salaries and wages	5,983,719	5,248,196
Employee benefits	1,357,703	1,220,078
Purchased healthcare	1,045,019	909,154
Professional fees	582,600	514,990
Supplies	2,072,005	1,792,707
Purchased services	1,105,189	977,247
Depreciation	630,537	676,357
Interest	153,480	155,343
Amortization	720	5,671
Other	1,240,993	762,082
Total operating expenses	14,171,965	12,261,825
Excess of revenues over expenses from operations	261,816	219,152
Net nonoperating (losses) gains:		
Gain from affiliations	—	476,110
Loss on extinguishment of debt	(69)	(85,522)
Investment (losses) income, net	(113,617)	178,043
Pension settlement costs and other	(71,305)	(16,361)
Total net nonoperating (losses) gains	(184,991)	552,270
Excess of revenues over expenses	76,825	771,422
Net assets released from restriction for capital	20,372	13,646
Change in noncontrolling interests in consolidated joint ventures	(398)	584
Pension related changes	(27,415)	(249,011)
Contributions, grants, and other	(20,231)	(8,639)
Increase in unrestricted net assets	$ 49,153	528,002

See accompanying notes to combined financial statements.

PROVIDENCE HEALTH & SERVICES

Combined Statements of Changes in Net Assets

Years ended December 31, 2015 and 2014

(In thousands of dollars)

	Unrestricted: controlling interest	Unrestricted: noncontrolling interest	Temporarily restricted	Permanently restricted	Total net assets
Balance, December 31, 2013	$ 6,964,906	44,718	223,548	84,313	7,317,485
Excess of revenues over expenses	771,422	—	—	—	771,422
Restricted contributions from affiliations	—	—	50,401	14,515	64,916
Contributions, grants, and other	(8,639)	—	93,563	7,429	92,353
Net assets released from restriction	13,646	—	(62,235)	—	(48,589)
Change in noncontrolling interests in consolidated joint ventures	—	584	—	—	584
Pension related changes	(249,011)	—	—	—	(249,011)
Increase in net assets	527,418	584	81,729	21,944	631,675
Balance, December 31, 2014	7,492,324	45,302	305,277	106,257	7,949,160
Excess of revenues over expenses	76,825	—	—	—	76,825
Contributions, grants, and other	(20,231)	—	88,214	17,721	85,704
Net assets released from restriction	20,372	—	(68,600)	—	(48,228)
Change in noncontrolling interests in consolidated joint ventures	—	(398)	—	—	(398)
Pension related changes	(27,415)	—	—	—	(27,415)
Increase in net assets	49,551	(398)	19,614	17,721	86,488
Balance, December 31, 2015	$ 7,541,875	44,904	324,891	123,978	8,035,648

See accompanying notes to combined financial statements.

PROVIDENCE HEALTH & SERVICES

Combined Statements of Cash Flows

Years ended December 31, 2015 and 2014

(In thousands of dollars)

		2015	2014
Cash flows from operating activities:			
Increase in net assets	$	86,488	631,675
Adjustments to reconcile increase in net assets to net cash provided by operating activities:			
Gains from affiliations		—	(541,026)
Depreciation and amortization		631,257	682,028
Provision for bad debt		185,567	193,018
Loss on extinguishment of debt		69	85,522
Equity income from joint ventures		(40,871)	(39,159)
Restricted contributions and investment income received		(112,763)	(94,024)
Net realized and unrealized losses (gains) on investments		187,912	(109,622)
Distributions from joint ventures		47,424	37,687
Changes in certain current assets and current liabilities		(492,347)	(21,062)
Change in certain long-term assets and liabilities		104,225	266,280
Net cash provided by operating activities		596,961	1,091,317
Cash flows from investing activities:			
Property, plant, and equipment additions		(637,262)	(537,301)
Proceeds from disposal of property, plant, and equipment		8,354	6,901
Purchases of investments		(6,851,705)	(5,555,329)
Proceeds from sales of investments		6,293,325	5,340,773
Change in other long-term assets and other		(12,463)	11,199
Change in funds held by trustee, net		(71,804)	(35,630)
Cash paid for affiliations, net of cash acquired		—	(98,958)
Net cash used in investing activities		(1,271,555)	(868,345)
Cash flows from financing activities:			
Proceeds from restricted contributions and restricted income		112,763	94,024
Debt borrowings		453,088	1,193,228
Debt payments		(400,379)	(1,112,836)
Other financing activities		1,106	(13,016)
Net cash provided by financing activities		166,578	161,400
(Decrease) increase in cash and cash equivalents		(508,016)	384,372
Cash and cash equivalents, beginning of year		1,237,337	852,965
Cash and cash equivalents, end of year	$	729,321	1,237,337
Supplemental disclosure of cash flow information:			
Cash paid for interest (net of amounts capitalized)	$	141,554	136,066

See accompanying notes to combined financial statements.

(1) Organization

(a) Sisters of Providence

Sisters of Providence (the Congregation), a religious congregation of Roman Catholic women, was founded in 1843. The religious congregation's central headquarters is in Montreal, Quebec, Canada. Sisters of Providence – Mother Joseph Province (the Province) was formed in 2000 through the combination of the Sacred Heart Province (founded in 1856) and the St. Ignatius Province (founded in 1891). The activities of the Province include apostolic works in healthcare, social services, and education. Members of the Province serve in these works through related and unrelated organizations. The Province is compensated for the services of its members. The Province has 130 professed members and maintains provincial administration offices in Renton, Washington. The members of the Province represent the Congregation in the following:

- Archdiocese of Los Angeles, California
- Archdiocese of Portland, Oregon
- Archdiocese of Seattle, Washington
- Diocese of Cubao, Philippines
- Diocese of Orlando, Florida
- Diocese of Spokane, Washington
- Diocese of Yakima, Washington
- Diocesis Santiago de Maria, El Salvador

(b) Providence Health & Services

The Public Juridic Person, Providence Ministries, is the sole Member of Providence Health & Services and controls certain aspects of the various corporations comprising Providence Health & Services through certain reserved rights.

Providence Ministries sponsors various corporations comprising Providence Health & Services including:

- Providence Health & Services – Washington
- Providence Health & Services – Oregon
- Providence Health System – Southern California (cosponsored by the Congregation and the American Province of the Little Company of Mary Sisters)
- Providence Health & Services – Montana
- Providence St. Joseph Medical Center
- St. Thomas Child and Family Center Corporation
- University of Great Falls

(Continued)

- Providence Plan Partners
- Providence Health Plan (the Health Plan)
- Providence Health Assurance
- Providence Health System Housing; The St. Luke Association; The Lundberg Association; Providence St. Francis Association; Providence Blanchet Association; Providence Rossi Association; Providence Peter Claver Association; The Gamelin Association; The Gamelin Oregon Association; The Gamelin California Association; Providence St. Elizabeth House Association; Gamelin Washington Association; Providence Gamelin House Association
- Providence Oregon Management Corporation
- Providence Ventures, Inc.
- Providence Assurance, Inc.
- Inland Northwest Health Services

Providence Ministries and Western HealthConnect are co-Members of Providence Health & Services – Western Washington.

Western HealthConnect, a secular Washington nonprofit corporation, is the sole corporate member of the following organizations:

- Swedish Health Services
- Swedish Edmonds
- Kadlec Regional Medical Center
- PacMed Clinics D/B/A Pacific Medical Centers
- Western HealthConnect Ventures, Inc.
- Health Connect Partners

Providence Health & Services and Western HealthConnect, inclusive of all sponsored and corporate members, are collectively referred to as the Health System.

The Health System owns or operates 34 general acute care hospitals, three ambulatory care centers, six medical groups, six long-term care facilities, seven homecare and hospice entities, five assisted living facilities, a high school, a university, 13 low-income housing projects, the Health Plan, a health services contractor, two programs of all inclusive care for the elderly, and 23 controlled fundraising foundations.

The Health System provides inpatient, outpatient, primary care, and home care services in Alaska, Washington, Montana, Oregon, and Southern California. The Health System operates these businesses primarily in the greater metropolitan areas of Anchorage, Alaska; Seattle, Spokane, Kennewick, and Olympia, Washington; Missoula, Montana; Portland and Medford, Oregon; and Los Angeles, California.

(Continued)

(c) Tax Exempt Status

The Health System and substantially all of the various corporations within the Health System have been recognized as exempt from federal income taxes, except on unrelated business income, under Section 501(a) of the Internal Revenue Code (IRC) as an organization described in Section 501(c)(3) of the IRC.

Providence Plan Partners, Providence Health Plan, and Providence Health Assurance are not-for-profit entities and have been recognized as exempt from federal income taxes, except on unrelated business income, as social welfare organizations under Section 501(c)(4) of the IRC.

(d) Organizational Changes

Affiliation Activity

Effective March 1, 2014, the Health System entered into an affiliation agreement with Sisters of Charity of Leavenworth Health System (SCL) to transfer sponsorship of Saint John's Health Center (Saint John's) to the Health System. Saint John's operates a nonprofit medical center, a cancer institute, and physician clinics to serve the Santa Monica, California community and surrounding area. The fair value of the net assets acquired was $430,728,000, which included $64,487,000 in restricted net assets. Unrestricted net assets of $366,241,000 exceeded total cash consideration of $186,217,000. The Health System recognized a gain from affiliation in the amount of $180,024,000 as the excess of the fair value of the unrestricted net assets over total consideration. The $64,487,000 of restricted net assets is recorded in restricted net assets in the combined statement of changes in net assets. The results of operations of Saint John's entities have been included in the combined statements of operations of the Health System effective as of the date of affiliation during 2014.

Effective May 1, 2014, the Health System entered into an affiliation agreement with PacMed Clinics (PacMed). PacMed is a private, nonprofit, multi-specialty medical group with nine clinics in the Puget Sound area and more than 150 primary care and specialty providers at the date of affiliation. Pursuant to the affiliation agreement, Western HealthConnect became PacMed's sole corporate Member. No cash or other purchase consideration was transferred to effect the affiliation. The results of operations of PacMed entities have been included in the combined statements of operations of the Health System effective as of the date of affiliation. The affiliation resulted in an excess of assets acquired over liabilities assumed, or a contribution from PacMed to the Health System of $84,717,000, which is included in gain from affiliation during 2014.

Effective June 13, 2014, the Health System entered into an affiliation agreement with Kadlec Health System (Kadlec). Kadlec operates a nonprofit medical center, a neurological resource center, a supporting foundation, and physician clinics to serve the area of Kennewick, Pasco, and Richland, Washington. Pursuant to the affiliation agreement, Western HealthConnect became the sole member of Kadlec. No cash or other purchase consideration was transferred to effect the affiliation. The results of operations of Kadlec have been included in the combined statements of operations of the Health System effective as of the date of affiliation. The affiliation resulted in an excess of assets acquired over liabilities assumed, or a contribution from Kadlec to the Health System of $211,798,000. The unrestricted portion of the contribution of $211,369,000 is included in gain from affiliation in the

accompanying combined statement of operations. The remaining $429,000 of the contribution is recorded in restricted net assets in the combined statement of changes in net assets during 2014.

The financial results of the affiliated entities discussed above are included in the Health System's 2014 combined statement of operations from the effective date of each respective affiliation through December 31, 2014. The following table summarizes the aggregate amounts included in the 2014 combined statement of operations (in thousands of dollars) related to the affiliated entities, excluding gain from affiliations:

Total operating revenues	$	648,634
Excess of revenues over expenses from operations		52,151
Excess of revenues over expenses		39,369

The following table summarizes the aggregate amounts included in the December 31, 2014 combined balance sheets related to the affiliated entities discussed above (in thousands of dollars):

Cash and investments	$	201,534
Accounts receivable, net of allowances		103,444
Property, plant, and equipment, net		594,323
Other assets		189,408
Total assets	$	1,088,709
Accounts payable and accrued compensation	$	93,604
Long-term debt, net of current portion		343,614
Other liabilities		97,571
Total liabilities		534,789
Net assets		553,920
Total liabilities and net assets	$	1,088,709

(2) Summary of Significant Accounting Policies

(a) Basis of Presentation

The financial statements of the Health System are presented on a combined basis due to the operational interdependence of the organization and because the respective Boards of Directors and corporate officers of Providence Health & Services and Western HealthConnect are comprised of the same individuals. All significant transactions and accounts between divisions and combined affiliates of the Health System have been eliminated. The Health System has performed an evaluation of subsequent events through March 9, 2016, which is the date these combined financial statements were issued.

(b) Use of Estimates

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

(c) Cash and Cash Equivalents

Cash and cash equivalents include investments in highly liquid debt instruments with an original or remaining maturity of three months or less when acquired.

(d) Supplies Inventory

Supplies inventory is stated at the lower of cost (first-in, first-out) or market.

(e) Property, Plant, and Equipment

Property, plant, and equipment are stated at cost. Improvements and replacements of plant and equipment are capitalized. Maintenance and repairs are expensed. The cost of the property, plant, and equipment sold or retired and the related accumulated depreciation are removed from the accounts, and the resulting gain or loss is recognized at the time of disposal.

The Health System assesses potential impairment to their long-lived assets when there is evidence that events or changes in circumstances have made recovery of the carrying value of the assets unlikely. An impairment loss, equal to the excess, if any, of the carrying value over the fair value less disposal costs, is recognized when the sum of the expected future undiscounted net cash flows from the use and disposal of the asset is less than the carrying amount of the asset.

(f) Depreciation

The provision for depreciation is determined by the straight-line method, which allocates the cost of tangible property equally over its estimated useful life or lease term.

(g) Capitalized Interest

Interest capitalized on amounts expended during construction is a component of the cost of additions to be allocated to future periods through the provision for depreciation. Capitalization of interest ceases when the addition is substantially complete and ready for its intended use. The Health System capitalized $10,573,000 and $4,044,000 of interest costs during the years ended December 31, 2015 and 2014, respectively.

(h) Financing Costs

Financing costs are recorded in other assets and are amortized using the effective-interest method over the term of the related debt, or to the earliest date at which a creditor can demand payment.

(i) Goodwill and Indefinite Lived Intangible Assets

Goodwill and indefinite lived intangible assets, which are not amortized as they are considered to have an indefinite life, are recorded in other assets as the excess of cost over fair value of the acquired net assets. Goodwill and indefinite lived intangible assets are tested at least annually for impairment.

(j) Intangible Assets with a Finite Life

Intangible assets that are determined to have a finite life are recorded in other assets. Such assets are amortized by the straight-line method, which allocates the cost of tangible property equally over the asset's estimated useful life or agreement term.

(k) Assets Whose Use Is Limited

The Health System has designated all of its investments in debt and equity securities, hedge funds, and collective investment funds as trading. These investments are reported on the combined balance sheets at fair value.

Assets whose use is limited primarily include assets held by trustees under indenture agreements, self-insurance funds, funds held for the payment of health plan medical claims and other statutory reserve requirements, assets held by related foundations, and designated assets set aside by the management of Providence Health & Services for future capital improvements and other purposes, over which management retains control.

Assets held by trustee obtained from borrowings under the Health System's master trust indenture for construction and other ongoing projects were $133,594,000 and $51,433,000 as of December 31, 2015 and 2014, respectively. Assets held by trustee for purposes of funding future obligations related to certain self-insurance programs and retirement plans were $171,075,000 and $190,819,000 at December 31, 2015 and 2014, respectively.

(l) Net Assets

Unrestricted net assets are those that are not subject to donor-imposed stipulations. Amounts related to the Health System's noncontrolling interests in certain joint ventures are included in unrestricted net assets. Temporarily restricted net assets are those whose use by the Health System has been limited by donors to a specific time period and/or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Health System in perpetuity. Unless specifically stated by donors, gains and losses on temporarily and permanently restricted net assets are recorded as temporarily restricted.

(m) Donor-Restricted Gifts

Unconditional promises to give cash and other assets to the Health System are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received. The gifts are reported as either temporarily or permanently restricted contributions if they are received with donor stipulations that limit the use of the donated assets. When the terms of a donor restriction are met, temporarily restricted net assets are reclassified as unrestricted net assets and reported as other operating revenues in the combined statements of operations or changes in net assets as net assets released from restriction.

(Continued)

(n) Net Patient Service Revenues

The divisions of the Health System have agreements with governmental and other third-party payors that provide for payments to the divisions at amounts different from the Health System's established charges. Payment arrangements for major third-party payors may be based on prospectively determined rates, reimbursed cost, discounted charges, per diem payments, predetermined rates per HMO enrollee per month, or other methods.

Net patient service revenues are reported at the estimated net realizable amounts due from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with governmental payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as appropriate. Adjustments from finalization of prior years' cost reports and other third-party settlement estimates resulted in an increase in net patient service revenues of $44,786,000 and $31,098,000 for the years ended December 31, 2015 and 2014, respectively.

The composition of significant third-party payors for the years ended December 31, 2015 and 2014, as a percentage of net patient service revenues, is as follows:

	2015	2014
Commercial	50%	52%
Medicare	32	33
Medicaid	17	14
Self-pay	1	1
	100%	100%

(o) Provision for Bad Debts

The Health System provides for an allowance against patient accounts receivable for amounts that could become uncollectible. The Health System estimates 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. The estimates made and changes affecting those estimates for the years ended December 31, 2015 and 2014 are summarized below:

	2015	2014
	(In thousands of dollars)	
Changes in allowance for doubtful accounts:		
Allowance for doubtful accounts at beginning of year	$ 289,908	358,966
Write-off of uncollectible accounts, net of recoveries	(131,640)	(262,076)
Provision for bad debts	185,567	193,018
Allowance for doubtful accounts at end of year	$ 343,835	289,908

(p) Premium Revenues, Premiums Receivable, Unearned Premiums, and Capitation Revenues

Health plan revenues consist of premiums paid by employers, individuals, and agencies of the federal and state governments for healthcare services. Health plan revenues are received on a prepaid basis and are recognized as revenue during the month for which the enrolled member is entitled to healthcare services. Premiums received for future months are recorded as unearned premiums.

Similar to health plan premiums, capitation revenues are received on a prepaid basis and are recognized as revenue during the month for which the enrolled member is entitled to healthcare services.

(q) Other Operating Revenues

Other operating revenues include meaningful use revenue, rental revenue, equity earnings from joint ventures, contributions released from restrictions, cafeteria revenue, and other miscellaneous revenue.

(r) Charity and Unsponsored Community Benefit Costs

The divisions of the Health System have policies that provide for serving those without the ability to pay. The policies also provide for discounted sliding scale payments based on the income and assets of the person responsible for the bill. In addition to uncompensated care, the Health System's divisions also provide services that benefit the poor and others in the communities they serve.

Information for the Health System for the years ended December 31, 2015 and 2014 is summarized below:

	2015	2014
	(In thousands of dollars)	
Cost of charity care provided	$ 180,256	205,555
Unpaid cost of Medicaid services	537,894	443,623
Unsponsored community benefit costs	$ 718,150	649,178

The cost of charity care provided is calculated based on each division's aggregate relationship of costs to charges. The unpaid cost of Medicaid services is the cost of treating Medicaid patients in excess of government payments. Unpaid cost of Medicaid services are net of revenues of $1,552,853,000 and $1,377,866,000 for the years ended December 31, 2015 and 2014, respectively.

(Continued)

(s) Net Nonoperating Losses and Gains

Net nonoperating gains primarily include investment income from trading securities, income from recipient organizations, pension settlement costs, and other income. Additionally, contributions from affiliations with Saint John's, PacMed, and Kadlec are included in net nonoperating gains in 2014.

(t) Excess of Revenues over Expenses

Excess of revenues over expenses includes all changes in unrestricted net assets, except for net assets released from restriction for the purchase of property, certain changes in funded status of postretirement benefit plans, net changes in noncontrolling interests in combined joint ventures, and other.

(u) Income and Other Taxes

The Health System recognizes the effect of income tax positions only if those positions are more likely than not of being sustained upon an audit by the taxing authority. Recognized income tax positions are measured at the largest amount that is greater than 50% likely of being realized. Changes in recognition or measurement are reflected in the period in which the change in judgment occurs.

Various states in which the Health System operates have instituted a provider tax on certain patient service revenues at qualifying hospitals to increase funding from other sources and obtain additional Federal funds to support increased payments to providers for Medicaid services. These taxes are included in other expenses in the accompanying combined statements of operations and were $527,789,000 and $129,384,000 for the years ended December 31, 2015 and 2014, respectively. These programs resulted in enhanced payments from these states in the way of lump-sum payments and per claim increases. These enhanced payments are included in net patient service revenues in the accompanying combined statements of operations and were $612,282,000 and $129,349,000 for the years ended December 31, 2015 and 2014, respectively.

(v) Recently Issued or Adopted Accounting Standards

In May 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update No. (ASU) 2014-09, *Revenue from Contracts with Customers (Topic 606)*, to clarify the principles for recognizing revenue and to improve financial reporting by creating common revenue recognition guidance for GAAP and International Financial Reporting Standards. The core principle of the new guidance is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The amendments in the ASU can be applied either retrospectively to each prior reporting period presented or retrospectively with the cumulative effect of initially applying the update recognized at the date of the initial application along with additional disclosures. The Health System is currently evaluating the impact of ASU 2014-09, including the methods of implementation, which is effective for the fiscal year beginning on January 1, 2018.

In March 2015, the FASB issued ASU 2015-03, *Simplifying the Presentation of Debt Issuance Costs*. This update changes the presentation of debt issuance costs in the financial statements. Under the ASU, an entity presents such costs in the balance sheet as a direct deduction from the recognized liability rather than as an asset. Amortization of the costs is reported as interest expense. The Health System

has considered the provisions of this standard and will adopt in the fiscal year beginning January 1, 2016. The Health System does not believe that the provisions of this standard will have a material impact in its combined financial statements.

In May 2015, the FASB issued ASU 2015-07, *Fair Value Measurement (Topic 820) – Disclosures for Investments in Certain Entities That Calculate Net Asset Value per Share (or Its Equivalent)*, which eliminates the requirement to categorize investments in the fair value hierarchy if their fair value is measured at net asset value per share, or its equivalent, (NAV) using the practical expedient in the FASB's fair value measurement guidance. The Health System adopted this standard effective December 31, 2015. As a result of the adoption of the standard, the Health System modified its fair value hierarchy disclosures.

In February 2016, the FASB issued ASU 2016-02, *Leases (Topic 842)*, which requires lessees to recognize a lease liability and a right of use asset for all lease obligations with exception to short-term leases. The lease liability will represent the lessee's obligation to make lease payments arising from the lease measured on a discounted basis and the right of use asset will represent the lessee's right to use or control the use of a specified asset for a lease term. The lease guidance also simplifies accounting for sale leaseback transactions. The Health System is currently evaluating the impact of ASU 2016-02, which is effective for the fiscal year beginning on January 1, 2019 with retrospective application to the earliest presented period.

(w) Reclassifications

Certain reclassifications have been made to prior year amounts to conform to the current year presentation.

(3) Fair Value of Financial Instruments

ASC Topic 820 (Topic 820), *Fair Value Measurements*, establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 inputs are quoted prices (unadjusted) in active markets for identical assets or liabilities that the Health System has the ability to access at the measurement date.
- Level 2 inputs are inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly.
- Level 3 inputs are unobservable inputs for the asset or liability.

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

The fair value of assets whose use is limited, other than those investments measured using NAV as a practical expedient for fair value, is estimated using quoted market prices or other observable inputs when quoted market prices are unavailable. For long-term debt, the fair value is based on Level 2 inputs, such as the

discounted value of the future cash flows using current rates for debt with the same remaining maturities, considering the existing call premium and protection. The carrying value and fair value of long-term debt, including accrued interest, was $4,149,702,000 and $4,438,718,000, respectively, as of December 31, 2015, and $4,097,789,000 and $4,421,616,000, respectively, as of December 31, 2014.

Other financial instruments of the Health System include cash and cash equivalents and other current assets and liabilities. The carrying amount of these instruments approximates fair value because these items mature in less than one year.

The following table presents the Health System's activity for assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) as defined in Topic 820 for the years ended December 31, 2015 and 2014 (in thousands of dollars):

Balance at December 31, 2013	$	25,950
Total realized and unrealized gains (losses), net		(2,257)
Total purchases		1,418
Total sales		(1,072)
Transfers into Level 3		2,997
Balance at December 31, 2014	$	27,036
Total realized and unrealized gains (losses), net		(131)
Total purchases		30,398
Total sales		(2,258)
Transfers into Level 3		10,982
Transfers out of Level 3		(3,895)
Balance at December 31, 2015	$	62,132

There were no significant transfers between assets classified as Level 1 and Level 2 during the years ended December 31, 2015 and 2014.

Level 3 assets include charitable remainder trusts, real property and equity investments in healthcare technology start-ups through the Health System's innovation venture capital fund. Fair values of real property were estimated using a market approach. Fair values of charitable remainder trusts were estimated using an income approach. Fair value of equity investments in healthcare technology start-ups were estimated using a combination of income and market approach.

(Continued)

(4) Assets Whose Use is Limited

The composition of assets whose use is limited at December 31, 2015 is set forth in the following table:

	December 31, 2015	Fair value measurements at reporting date using		
		Level 1	Level 2	Level 3
		(In thousands of dollars)		
Management-designated cash and investments:				
Cash and cash equivalents	$ 613,736	613,736	—	—
Domestic equity securities:				
Mutual funds:				
Large capitalization	183,018	183,018	—	—
Medium-small cap and other	149,291	149,291	—	—
Technology	133,510	133,510	—	—
Financial services	103,049	103,049	—	—
Consumer services	93,663	93,663	—	—
Other industries	196,044	196,044	—	—
Foreign equity securities:				
Mutual funds:				
Large capitalization	91,639	91,639	—	—
Medium-small cap and other	64,545	64,545	—	—
Other industries	68,034	68,034	—	—
Debt securities – U.S. Treasury	1,001,525	717,466	284,059	—
Debt securities – State Treasury	27,754	—	27,754	—
Domestic corporate debt securities	643,590	—	643,590	—
Foreign corporate debt securities	87,423	—	87,423	—
Other	272,782	515	272,267	—
Investments measured using NAV	1,401,506			
Total management-designated cash and investments	$ 5,131,109			
Gift annuities, trusts, and other	$ 93,804	23,856	7,816	62,132
Funds held by trustee:				
Cash and cash equivalents	$ 176,134	176,134	—	—
Domestic equity securities	334	334	—	—
Foreign equity securities	162	162	—	—
Debt securities – U.S. Treasury	64,874	63,650	1,224	—
Domestic corporate debt securities	48,478	—	48,478	—
Foreign corporate debt securities	15,971	—	15,971	—
Collateralized debt securities	21,108	—	21,108	—
Other	581	87	494	—
Total funds held by trustee	$ 327,642			

(Continued)

The composition of assets whose use is limited at December 31, 2014 is set forth in the following table:

	December 31, 2014	Fair value measurements at reporting date using		
		Level 1	Level 2	Level 3
		(In thousands of dollars)		
Management-designated cash and investments:				
Cash and cash equivalents	$ 401,728	401,728	—	—
Domestic equity securities:				
Mutual funds:				
Large capitalization	139,544	139,544	—	—
Medium-small cap and other	143,501	143,501	—	—
Consumer services	269,565	269,565	—	—
Financial services	129,676	129,676	—	—
Technology	105,950	105,950	—	—
Other industries	120,761	120,761	—	—
Foreign equity securities:				
Mutual funds				
Large capitalization	177,185	177,185	—	—
Medium-small cap and other	39,315	39,315	—	—
Other industries	83,455	83,455	—	—
Debt securities – U.S. Treasury	1,211,814	1,054,362	157,452	—
Debt securities – State Treasury	21,926	81	21,845	—
Domestic corporate debt securities	532,840	—	532,840	—
Foreign corporate debt securities	96,487	—	96,487	—
Other	177,374	12,216	162,504	2,654
Investments measured using NAV	1,149,370			
Total management-designated cash and investments	$ 4,800,491			
Gift annuities, trusts, and other	$ 53,954	20,454	9,118	24,382
Funds held by trustee:				
Cash and cash equivalents	$ 85,038	85,038	—	—
Domestic equity securities	22,159	22,159	—	—
Foreign equity securities:	1,900	1,900	—	—
Debt securities – U.S. Treasury	84,725	82,125	2,600	—
Domestic corporate debt securities	32,017	—	32,017	—
Foreign corporate debt securities	19,953	—	19,953	—
Mortgage-backed securities	5,956	—	5,956	—
Other	4,090	—	4,090	—
Total funds held by trustee	$ 255,838			

(Continued)

The Health System participates in various funds that are not actively marketed on an open exchange. These investments consist of shares or units in investment funds as opposed to direct interests in the funds' underlying holdings, which may be marketable. Due to the nature of these funds the net asset value per share, or its equivalent, reported by each fund manager is used as a practical expedient to estimate the fair value of the Health System's interest therein. Management believes that the carrying amounts of these financial instruments, provided by the fund managers, are reasonable estimates of fair value.

The following table presents information for investments where the NAV was used to value the investments as of December 31 (in thousands of dollars):

	Fair value		Unfunded Commitments	Redemption frequency	Redemption notice period
	2015	2014			
Hedge funds					
Relative value	$ 180,756	159,753	—	Quarterly	60 – 90 days
Risk parity	155,928	148,543	—	Monthly	5 – 15 days
Growth	169,490	151,218	—	Quarterly	45 – 90 days
Diversified	83,274	85,712	—	Monthly	2 – 90 days
Other	14,613	7,517	—	Monthly or Quarterly	30 – 90 days
Collective investment funds:					
Equities	572,214	522,009	—	Monthly	6 – 60 days
Fixed income	216,243	74,618	—	Daily	3 days
Private equity	8,988	—	75,408	Not applicable	Not applicable
Total	$ 1,401,506	1,149,370	75,408		

The following is a summary of the nature of these investments and their associated risks:

Hedge funds are portfolios of investments that use advanced investment strategies such as leveraged, long, short, and derivative positions in both domestic and international markets with the goal of diversifying portfolio risk and generating return. The Health System's investments in hedge funds include $44,980,000 subject to lockup provisions that limit the Health System's ability to access cash for one or more years from the initial investment.

Collective investment funds are funds that pursue diversification of domestic and foreign equity and fixed income securities. The Health System's investments in collective investment funds have no lockup provisions or other restrictions, other than outlined in the table above, that limit its ability to access cash.

Private equity funds are funds that make opportunistic investments that are primarily private in nature. These investments cannot be redeemed by the Health System; rather the Health System has committed an amount to invest in the private funds over the respective commitment periods. After the commitment period has ended, the nature of the investments in this category is that the distributions are received through the liquidation of the underlying assets.

The Health System offsets the fair value of various investment derivative instruments when executed with the same counterparty under a master netting arrangement. The Health System invests in a variety of investment derivative instruments through a fixed-income manager that has executed a master netting arrangement with the counterparties of each of its futures and forward currency purchase and sale contracts

whereby the financial instruments held by the same counterparty are legally offset as the instruments are settled.

The following table presents gross investment derivative assets and liabilities reported on a net basis included in management-designated investments in the combined balance sheets:

	2015 (In thousands of dollars)
Derivative assets:	
Futures contracts	$ 404,677
Forward currency and other contracts	41,617
	446,294
Derivative liabilities:	
Futures contracts	(404,677)
Forward currency and other contracts	(42,289)
	(446,966)

Investment derivative instruments, reported in management-designated investments in the combined balance sheets, are recorded at fair value.

The Health System's management designated cash and investments include funds held on behalf of non-controlled entities of $59,569,000 and $0 at December 31, 2015 and 2014, respectively. An offsetting liability to recognize the obligation back to the non-controlled entities is included in other liabilities in the accompanying combined balance sheets.

Investment income from management-designated cash and investments and funds held by trustee are included in net nonoperating gains and are comprised of the following for the years ended December 31, 2015 and 2014:

	2015	2014
	(In thousands of dollars)	
Interest income	$ 64,797	71,108
Net realized gains on sale of investments	25,280	365,413
Change in net unrealized losses on trading securities	(203,694)	(258,478)
Total	$ (113,617)	178,043

(Continued)

(5) Property, Plant, and Equipment

Property, plant, and equipment and the total accumulated depreciation at December 31, 2015 and 2014 are shown below:

	Approximate useful life (years)	2015	2014
		(In thousands of dollars)	
Land	—	$ 757,469	756,304
Buildings and improvements	5–60	5,834,374	5,643,827
Equipment:			
Fixed	5–25	1,055,751	1,041,956
Major movable and minor	3–20	4,405,945	4,138,703
Rental property	15–40	914,353	898,609
Construction in progress	—	274,883	216,549
		13,242,775	12,695,948
Less accumulated depreciation		6,661,915	6,073,382
Property, plant, and equipment, net		$ 6,580,860	6,622,566

Construction in progress primarily represents renewal and replacement of various facilities in the Health System's operating divisions, as well as costs capitalized related to software development.

(6) Other Assets

Other assets at December 31, 2015 and 2014 are as follows:

	2015	2014
	(In thousands of dollars)	
Unamortized financing costs, net	$ 34,639	35,744
Investment in nonconsolidated joint ventures	141,182	116,747
Interest in noncontrolled foundations	128,341	136,597
Notes receivable	45,889	37,989
Long-term reinsurance receivable	33,032	39,530
Goodwill and intangibles	169,584	163,540
Other	20,301	38,737
Total other assets	$ 572,968	568,884

The Health System participates in various joint ventures for the purpose of furthering its healthcare mission. These joint ventures exist in all geographic locations in which the Health System operates. The primary purposes of the ventures are to provide outpatient services such as laboratory, outpatient surgery, and medical imaging. Various joint ventures, throughout the Health System, are controlled and consequently are

combined in the financial statements of the Health System. All other joint ventures are accounted for under the equity method of accounting. The Health System recorded earnings from equity method investees of $40,871,000 and $39,159,000 for the years ended December 31, 2015 and 2014, respectively, the majority of which are included in other operating revenues in the accompanying combined statements of operations.

(7) Short-Term and Long-Term Debt

The Health System has borrowed Master Trust debt issued through the following:

- California Health Facilities Financing Authority (CHFFA)
- Alaska Industrial Development and Export Authority (AIDEA)
- Hospital Facilities Authority of Multnomah County (HFAMC)
- Washington Health Care Facilities Authority (WHCFA)
- Montana Facility Finance Authority (MFFA)
- Oregon Facilities Authority (OFA)

(Continued)

Short-term and long-term unpaid principal at December 31, 2015 and 2014 consists of the following:

	Maturing through	Coupon rates	Unpaid principal 2015	Unpaid principal 2014
			(In thousands of dollars)	
Master trust debt:				
Fixed:				
Series 1996, CHFFA Revenue Bonds	2015	4.00 – 6.00%	$ —	2,035
Series 1997, Direct Obligation Notes	2017	7.70%	1,445	2,090
Series 2003H, AIDEA Revenue Bonds	2015	4.63 – 5.25%	—	4,600
Series 2005, Direct Obligation Notes	2030	4.31 – 5.39%	44,380	46,295
Series 2006A, WHCFA Revenue Bonds	2036	4.50 – 5.00%	210,555	210,555
Series 2006B, MFFA Revenue Bonds	2026	4.00 – 5.00%	54,495	58,170
Series 2006C, WHCFA Revenue Bonds	2033	5.25%	69,425	69,425
Series 2006D, WHCFA Revenue Bonds	2033	5.25%	69,275	69,275
Series 2006E, WHCFA Revenue Bonds	2033	5.25%	26,350	26,350
Series 2006H, AIDEA Revenue Bonds	2036	5.00%	51,905	54,355
Series 2008C, CHFFA Revenue Bonds	2038	3.00 – 6.50%	15,785	17,715
Series 2009A, Direct Obligation Notes	2019	5.05 – 6.25%	165,000	165,000
Series 2009B, CHFFA Revenue Bonds	2039	5.50%	150,000	150,000
Series 2010A, WHCFA Revenue Bonds	2039	4.88 – 5.25%	174,240	174,240
Series 2011A, AIDEA Revenue Bonds	2041	5.00 – 5.50%	122,720	122,720
Series 2011B, WHCFA Revenue Bonds	2021	2.00 – 5.00%	58,995	67,390
Series 2011C, OFA Revenue Bonds	2026	3.50 – 5.00%	18,375	20,405
Series 2012A, WHCFA Revenue Bonds	2042	2.00 – 5.00%	497,850	503,955
Series 2012B, WHCFA Revenue Bonds	2042	4.00 – 5.00%	100,000	100,000
Series 2013A, OFA Revenue Bonds	2024	2.00 – 5.00%	66,600	72,515
Series 2013D, Direct Obligation Notes	2023	4.38%	252,285	252,285
Series 2014A, CHFFA Revenue Bonds	2038	2.00 – 5.00%	274,465	275,850
Series 2014B, CHFFA Revenue Bonds	2044	4.25 – 5.00%	118,740	118,740
Series 2014C, WHCFA Revenue Bonds	2044	4.00 – 5.00%	92,245	92,245
Series 2014D, WHCFA Revenue Bonds	2041	5.00%	178,770	178,770
Series 2015A, WHCFA Revenue Bonds	2045	4.00%	77,635	—
Series 2015C, OFA Revenue Bonds	2045	4.00 – 5.00%	71,070	—
Total fixed			2,962,605	2,854,980
Variable:				
Series 2012C, WHCFA Revenue Bonds	2042	0.05%	80,000	80,000
Series 2012D, WHCFA Revenue Bonds	2042	0.05%	80,000	80,000
Series 2012E, Direct Obligation Notes	2042	0.17%	233,525	235,705
Series 2013C, OFA Revenue Bonds	2022	1.08%	135,375	148,750
Series 2013E, Direct Obligation Notes	2017	3.00%	200,000	322,250
Total variable			728,900	866,705

(Continued)

	Maturing through	Coupon rates	Unpaid principal 2015	2014
			(In thousands of dollars)	
Commercial Paper, Series 2015B	2016	0.21%	125,000	—
U.S. Bank Credit Facility	2016	0.56%	12,500	12,500
Unpaid principal, master trust debt			3,829,005	3,734,185
Premiums and discounts, net			117,320	123,941
Master trust debt, including premiums and discounts, net			3,946,325	3,858,126
Other long-term debt			165,502	200,923
Total debt			$ 4,111,827	4,059,049

	2015	2014
	(In thousands of dollars)	
Current portion of long-term debt	$ 244,532	202,287
Short-term master trust debt	137,500	12,500
Long-term debt, classified as a long-term liability	3,729,795	3,844,262
Total debt	$ 4,111,827	4,059,049

An Obligated Group was formed for issuing debt under a master trust indenture. Members of the Obligated Group are jointly and severally responsible for all borrowings under the master trust indenture of the Obligated Group. The master trust indenture and bond trust indentures for each debt issue require the Obligated Group to meet certain financial covenants. The members of the Obligated Group include the following:

- Providence Health & Services – Washington (exclusive of Inland Northwest Health Services)
- Western HealthConnect
- Providence Health & Services – Oregon (exclusive of Providence Plan Partners)
- Providence Health System – Southern California (exclusive of Medical Institute of Little Company of Mary, Lifecare Ventures, Inc., TrinityCare Hospice, and Facey)
- Providence St. Joseph Medical Center, and Providence Health & Services – Montana

The Obligated Group excludes related housing projects financed by the U.S. Department of Housing and Urban Development and foundations.

In August and September 2015, the Health System issued $77,635,000 of Series 2015A WHCFA fixed rate revenue bonds and $71,070,000 of Series 2015C OFA fixed rate revenue bonds, respectively. The intended use of funds was to cover certain capital investment.

In November 2014, the Health System issued $178,770,000 of Series 2014D WHCFA fixed rate revenue bonds. The proceeds were used to redeem Series 2006B WHCFA revenue bonds, Series 2006A WHCFA revenue bonds, Series 2010 WHCFA revenue bonds, and Series 2012 WHCFA revenue bonds, which were

issued by Kadlec prior to the affiliation. In connection with the Series 2014D issuance, Kadlec became a member of the Obligated Group.

In September 2014, the Health System issued $92,245,000 of Series 2014C WHCFA fixed rate revenue bonds. The proceeds were used for the partial redemption of Series 2009A PHS Direct Obligation bonds. In connection with the Series 2014C issuance, Swedish Edmonds and PacMed became members of the Obligated Group.

In August 2014, the Health System issued $118,740,000 of Series 2014B CHFFA fixed rate revenue bonds. The proceeds were used to redeem Series 2013F Commercial Paper, which was issued to finance the purchase of Saint John's. In connection with the Series 2014B issuance, Saint John's became a member of the Obligated Group.

In June 2014, the Health System issued $275,850,000 of Series 2014A CHFFA fixed rate revenue bonds. The proceeds were used for the partial redemption of Series 2008C CHFFA bonds.

In connection with the Series 2015A-C issuances and the Series 2014A-D issuances, the Health System recorded losses due to extinguishment of debt of $69,000 and $85,522,000 in 2015 and 2014, respectively, which were recorded in net nonoperating gains in the accompanying combined statements of operations.

(a) Master Trust Debt Classified as Short-Term

Commercial Paper, Series 2015B

In September 2015, the Health System issued Series 2015B commercial paper obligations. During 2015, the Health System made principal and interest payments on matured commercial paper and reissued new commercial paper, maintaining a balance ranging between $27,000,000 and $125,000,000 throughout the year. The average interest rate in effect during 2015 was 0.21%.

U.S. Bank Credit Facility

The Health System has a $150,000,000 Credit Facility with U.S. Bank, of which $12,500,000 in borrowings was outstanding at December 31, 2015 and 2014.

(b) Other Long-Term Debt

Other long-term debt primarily includes capital leases, notes payable, and bonds that are not under the master trust indenture. Other long-term debt at December 31, 2015 and 2014 consists of the following:

	2015	2014
	(In thousands of dollars)	
Capital leases	$ 103,789	114,963
Notes payable	46,988	74,381
Bonds not under master trust indenture and other	14,725	11,579
Total other long-term debt	$ 165,502	200,923

(Continued)

Scheduled principal payments of long-term debt, considering all obligations under the master trust indenture as due according to their long-term amortization schedule, for the next five years and thereafter are as follows:

	Master trust	Other	Total
		(In thousands of dollars)	
2016	$ 221,535	22,997	244,532
2017	160,175	18,825	179,000
2018	62,960	8,800	71,760
2019	165,895	8,074	173,969
2020	68,830	8,092	76,922
Thereafter	3,012,110	98,714	3,110,824
Scheduled principal payments of long-term debt	3,691,505	$ 165,502	3,857,007
Short-term master trust debt	137,500		
Total master trust debt	$ 3,829,005		

Leases

The Health System leases various medical and office equipment and buildings under operating leases. Future minimum lease commitments under noncancelable operating leases for the next five years and thereafter are as follows (in thousands of dollars):

2016	$ 124,188
2017	116,588
2018	103,487
2019	94,394
2020	82,802
Thereafter	613,139
	$ 1,134,598

Rental expense was $216,657,000 and $193,875,000 for the years ended December 31, 2015 and 2014, respectively, and is included in other expenses in the accompanying combined statements of operations.

(8) Retirement Plans

(a) Defined Benefit Plans

Cash Balance Retirement Plan

The Health System had a noncontributory cash balance plan covering substantially all Providence employees called the Providence Health & Services Cash Balance Retirement Plan Trust (the Cash Balance Plan). The plan was frozen effective December 31, 2009. The plan benefits are based on

defined average compensation and years of service. The plan has a five-year cliff vesting schedule. The Health System's funding policy is based on the actuarially determined cost method, and includes normal service cost and prior service costs amortized over a 20-year period. Under the Cash Balance Plan, each employee carries an individual account balance. The Health System makes an annual contribution and provides an annual interest credit to each employee's account.

Supplemental Executive Retirement Plan

The Health System has a noncontributory supplemental executive retirement plan (the SERP) covering certain employees who were employed in certain key positions or pay grades or that have been designated by the Health System. The plan was frozen effective December 31, 2009. The plan benefits were based on defined average compensation and years of service. The vesting period for the plan requires an executive attain age 55 with at least five years of eligible service. The Health System's funding policy is based on the actuarially determined cost method, and includes normal service cost and prior service costs amortized over a 20-year period. Under the SERP, each employee carries an individual account balance. The Health System makes an annual contribution and provides an annual interest credit to each employee's account.

Swedish Health Services Pension Plan

The Swedish Health Services Pension Plan (the Pension Plan) is a noncontributory plan covering a majority of Swedish employees, and provides benefits based on number of years of credited service and compensation earned during the participation in the Pension Plan. The Pension Plan is frozen to all former and existing nonrepresented employees and to all new participants. Only represented employees that were active in the plan on December 31, 2009 remain in the plan actively accruing benefits. The Health System makes annual contributions to the Pension Plan.

Willamette Falls Pension Plan

The Willamette Falls Pension Plan is also a noncontributory plan covering a majority of employees at Providence Willamette Falls. The plan was frozen effective February 2008. The plan benefits are based on years of service and compensation during an employee's period of employment. The funding policy is based on the actuarially determined cost method, and includes normal service cost and prior service costs amortized over a 20-year period. Under the Willamette Falls Pension Plan, each employee carries an individual monthly annuity benefit.

The Cash Balance Plan, the SERP, the Pension Plan, and the Willamette Falls Pension Plan are collectively "the defined benefit plans."

The Health System's contributions to these defined benefit plans for the years ended December 31, 2015 and 2014 were $90,562,000 and $100,380,000, respectively.

(Continued)

The measurement dates for the defined benefit plans are December 31, 2015 and 2014. A rollforward of the change in benefit obligation and change in the fair value of plan assets for the defined benefit plans is as follows:

		2015	2014
		(In thousands of dollars)	
Change in projected benefit obligation:			
Projected benefit obligation at beginning of year	$	2,827,325	2,592,617
Service cost		24,858	22,851
Interest cost		113,956	124,911
Actuarial (gain) loss		(134,753)	289,225
Benefits paid and other		(231,159)	(202,279)
Projected benefit obligation at end of year		2,600,227	2,827,325
Change in fair value of plan assets:			
Fair value of plan assets at beginning of year		1,782,250	1,773,628
Actual return on plan assets		(106,400)	110,521
Employer contributions		90,562	100,380
Benefits paid and other		(231,159)	(202,279)
Fair value of plan assets at end of year		1,535,253	1,782,250
Funded status		(1,064,974)	(1,045,075)
Unrecognized net actuarial loss		470,429	441,783
Unrecognized prior service cost		5,068	6,299
Net amount recognized	$	(589,477)	(596,993)
Amounts recognized in the consolidated balance sheets consist of:			
Current liabilities	$	(1,393)	(4,136)
Noncurrent liabilities		(1,063,581)	(1,040,939)
Unrestricted net assets		475,497	448,082
Net amount recognized	$	(589,477)	(596,993)
Weighted average assumptions:			
Discount rate		4.58%	4.20%
Rate of increase in compensation levels		3.50	3.50
Long-term rate of return on assets		6.80	7.00

(Continued)

Net periodic pension cost for the defined benefit plans for 2015 and 2014 includes the following components:

	2015	2014
	(In thousands of dollars)	
Components of net periodic pension cost:		
Service cost	$ 24,858	22,851
Interest cost	113,956	124,911
Expected return on plan assets	(115,711)	(118,676)
Amortization of prior service cost	1,231	1,231
Recognized net actuarial loss	26,163	14,340
Settlement expense	32,549	32,798
Net periodic pension cost	$ 83,046	77,455

Total expense for all of the Health System's defined benefit plans for the years ended December 31, 2015 and 2014 was $83,046,000 and $77,455,000, respectively. Included in the total expense is $32,549,000 and $32,798,000 of settlement costs that were incurred in 2015 and 2014, respectively, related to settlements that were greater than the sum of the service cost and interest cost components of net periodic pension cost. This settlement expense is included in net nonoperating gains in the accompanying combined statements of operations. The remaining expense for the defined benefit plans is included in employee benefits in the accompanying combined statements of operations.

The accumulated benefit obligation was $2,555,741,000 and $2,771,511,300 at December 31, 2015 and 2014, respectively.

The following pension benefit payments reflect expected future service. Payments expected to be paid over the next 10 years are as follows (in thousands of dollars):

2016	$ 194,339
2017	176,086
2018	186,764
2019	192,506
2020 – 2025	1,104,643
	$ 1,854,338

The Health System expects to contribute approximately $71,600,000 to the defined benefit plans in 2016.

The expected long-term rate of return on plan assets is the expected average rate of return on the funds invested currently and on funds to be invested in the future in order to provide for the benefits included in the projected benefit obligation. The Health System used 6.8% and 7.0% in calculating the 2015 and 2014 expense amounts, respectively. This assumption is based on capital market assumptions and the plan's target asset allocation.

(Continued)

The Health System continues to monitor the expected long-term rate of return. If changes in those parameters cause 6.8% to be outside of a reasonable range of expected returns, or if actual plan returns over an extended period of time, suggest that general market assumptions are not representative of expected plan results, the Health System may revise this estimate prospectively.

Target asset allocation and expected long-term rate of return on assets (ELTRA) for the years ended December 31, 2015 and 2014, respectively, were as follows:

	2015 Target	2015 ELTRA	2014 Target	2014 ELTRA
Cash and cash equivalents	2%	1% – 3%	5%	1% – 4%
Equity securities	47	5% – 8%	35	5% – 8%
Debt securities	35	2% – 6%	50	3% – 5%
Other securities	16	5% – 8%	10	6% – 9%
Total	100%	6.80%	100%	7.00%

(Continued)

The following table presents the Health System's defined benefit plan assets measured at fair value at December 31, 2015:

	December 31, 2015	Fair value measurements at reporting date using		
		Level 1	Level 2	Level 3
		(In thousands of dollars)		
Assets:				
Cash and cash equivalents	$ 38,530	38,530	—	—
Domestic equity securities:				
Mutual funds:				
Large capitalization	16,180	16,180	—	—
Technology	63,668	63,668	—	—
Financial services	52,988	52,988	—	—
Consumer services	48,814	48,814	—	—
Other	96,105	96,105	—	—
Foreign equity securities:				
Mutual funds:				
Large capitalization	14,487	14,487	—	—
Consumer services	14,216	14,216	—	—
Technology	10,693	10,693	—	—
Other	11,983	11,983	—	—
Debt securities – state and government	242,808	169,396	73,412	—
Foreign securities – state and government	7,500	—	7,500	—
Domestic corporate debt securities	115,999	—	115,999	—
Foreign corporate debt securities	15,095	—	15,095	—
Other	7,781	—	7,781	—
Investments measured using NAV	778,406			
Total	$ 1,535,253			

(Continued)

The following table presents the Health System's defined benefit plan assets measured at fair value at December 31, 2014:

	December 31, 2014	Fair value measurements at reporting date using		
		Level 1	Level 2	Level 3
		(In thousands of dollars)		
Assets:				
Cash and cash equivalents	$ 44,670	44,670	—	—
Domestic equity securities:				
Mutual funds:				
Medium-small cap and other	2,252	2,252	—	—
Consumer services	184,842	184,842	—	—
Financial services	68,769	68,769		
Technology	45,304	45,304	—	—
Other	62,558	62,558	—	—
Foreign equity securities:				
Mutual funds:				
Large capitalization	44,450	44,450	—	—
Consumer services	15,809	15,809	—	—
Technology	11,777	11,777	—	—
Other	19,809	19,809	—	—
Debt securities – state and government	281,432	208,804	72,628	—
Foreign securities – state and government	14,596	—	14,596	—
Domestic corporate debt securities	129,564	—	129,564	—
Foreign corporate debt securities	22,291	—	22,291	—
Other	13,108	3,246	9,862	—
Investments measured using NAV	821,019			
Total	$ 1,782,250			

The Health System defined benefit plans participate in various funds that are not actively marketed on an open exchange. These investments consist of shares or units in investment funds as opposed to direct interests in the funds' underlying holdings, which may be marketable. Due to the nature of these funds the net asset value per share, or its equivalent, reported by each fund manager is used as a practical expedient to estimate the fair value of the Health System's interest therein. Management believes that the carrying amounts of these financial instruments, provided by the fund managers, are reasonable estimates of fair value.

(Continued)

The following table presents information for investments where either the NAV per share or its equivalent was used to value the investments as of December 31:

	Fair value 2015	Fair value 2014	Redemption frequency	Redemption notice period
Hedge funds				
Risk parity	$ 125,398	138,886	Monthly	5 – 15 days
Growth	142,320	140,305	Quarterly	45 – 90 days
Other	1,444	2,993	Monthly or Quarterly	30 – 90 days
Collective investment funds:				
Equities	355,462	349,662	Monthly	6 – 60 days
Fixed income	153,782	189,173	Daily	3 days
Total	$ 778,406	821,019		

There were no significant transfers between assets classified as Level 1 and Level 2 during the years ended December 31, 2015 and 2014.

(b) Defined Contribution Plans

401(a) Service Plan

The Health System sponsors the Providence Health & Services 401(a) Service Plan (the Service Plan). The Service Plan covers substantially all Providence employees, with contributions based on defined eligible compensation and years of service. The plan has a five-year cliff vesting schedule. The Health System contributed $153,563,000 to the Service Plan in 2015 related to prior years, and has accrued a liability of $161,947,000 as of December 31, 2015 related to contributions to be made in 2016 for plan year 2015. The accrued balance has been included in the current portion of retirement plan obligations on the accompanying combined balance sheets.

403(b) Value Plan

The Health System also sponsors the Providence Health & Services 403(b) Value Plan (the Value Plan). The plan is a defined contribution plan, which includes a qualified cash or deferred arrangement, for the benefit of eligible employees. Vesting is immediate. Total Value Plan expense, primarily related to contributions, was $77,070,000 and $74,760,000 in 2015 and 2014, respectively, and is included in employee benefits expense in the accompanying combined statements of operations.

Providence, Swedish, PAML Multiple Employer 401(k) Plan

The Health System sponsors the Providence, Swedish, PAML Multiple Employer 401(k) Plan which covers certain Providence affiliates unable to participate in the Service Plan and the Value Plan. The plan is a defined contribution plan with contributions based on defined eligible compensation. The plan has a four-year cliff vesting schedule. Total plan expense, primarily related to contributions, was $47,590,000 and $42,781,000 in 2015 and 2014, respectively, and is included in employee benefits expense in the accompanying combined statements of operations.

(Continued)

(9) Self-Insurance Liability

The Health System has established self-insurance programs for professional and general liability and workers' compensation insurance coverage. These programs provide insurance coverage for healthcare institutions associated with the Health System. The Health System also operates an insurance captive, Providence Assurance, Inc., to self-insure or reinsure certain layers of professional and general liability risk.

The Health System accrues estimated self-insured professional and general liability and workers' compensation insurance claims based on management's estimate of the ultimate costs for both reported claims and actuarially determined estimates of claims incurred-but-not-reported. Insurance coverage in excess of the per occurrence self-insured retention, has been secured with insurers or reinsurers for specified amounts for professional, general, and workers' compensation liabilities. Decisions relating to the limit and scope of the self-insured layer and the amounts of excess insurance purchased are reviewed each year, subject to management's analysis of actuarial loss projections and the price and availability of acceptable commercial insurance.

At December 31, 2015 and 2014, the estimated liability for future costs of professional and general liability claims was $249,013,000 and $232,639,000, respectively. At December 31, 2015 and 2014, the estimated workers' compensation obligation was $162,728,000 and $150,845,000, respectively, in the accompanying combined balance sheets. At December 31, 2015 and 2014, $292,843,000 and $274,541,000, respectively, of these amounts were included as self-insurance liability, net of current portion, with the remainder included within current portion of self-insurance liability, in the accompanying combined balance sheets.

(10) Commitments

Firm purchase commitments, primarily related to construction, software, and supplies, at December 31, 2015, are approximately $163,590,000.

(11) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at December 31, 2015 and 2014:

	2015	2014
	(In thousands of dollars)	
Program support	$ 184,340	160,842
Low-income housing	32,950	34,036
Capital acquisition and other	107,601	110,399
Total temporarily restricted net assets	$ 324,891	305,277

The Health System's fundraising foundations have obtained contributions to support the various programs offered by the Health System. Many of these contributions remain temporarily restricted as of December 31, 2015 and 2014 because the time or purpose restrictions stipulated by the donor have not been met. Generally, program support consists of items that will defray the cost of operating certain patient care activities of the Health System.

(Continued)

Other revenues included $48,228,000 and $48,589,000 of assets released from restriction for operations for the years ended December 31, 2015 and 2014, respectively.

Permanently restricted net assets are restricted to investments in perpetuity, the income of which is expendable primarily for program support.

(12) Litigation and Contingencies

The healthcare industry is subject to numerous laws and regulations from federal, state, and local governments. Compliance with these laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time. Government monitoring and enforcement activity continues with respect to investigations and allegations concerning possible violations by healthcare providers of regulations, which could result in the imposition of significant fines and penalties, as well as significant repayments of patient services previously billed. Institutions within the Health System are subject to similar regulatory reviews.

Management is aware of certain asserted and unasserted legal claims and regulatory matters arising in the course of business. After consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on the Health System's combined financial statements.

(13) Functional Expenses

The Health System provides healthcare services to residents within its geographic service areas. Expenses related to providing these services for the years ended December 31, 2015 and 2014 are as follows:

	2015	2014
	(In thousands of dollars)	
Healthcare expenses	$ 10,700,175	9,199,881
Purchased healthcare expenses	1,045,019	909,154
General and administrative expenses	2,426,771	2,152,790
Total operating expenses	$ 14,171,965	12,261,825

Schedule 1

PROVIDENCE HEALTH & SERVICES

Supplemental Schedule – Balance Sheet Information

December 31, 2015 (with combined totals for 2014)

(In thousands of dollars)

Assets	Alaska	Washington	Montana	Oregon	Providence Plan Partners	Southern California	System office, eliminations, and other	2015 Total Health System	2014 Total Health System
Current assets:									
Cash and cash equivalents	$ 213,952	191,084	7,779	207,553	74,695	(113,363)	147,621	729,321	1,237,337
Short-term management-designated investments	—	—	—	—	—	18,721	181,530	200,251	199,338
Accounts receivable, net	160,005	815,096	51,729	319,025	—	298,333	(74,361)	1,569,827	1,419,495
Other receivables, net	20,088	939,747	82,816	98,241	53,994	109,741	(905,336)	399,291	375,185
Supplies inventory	12,605	85,491	5,991	37,507	—	28,461	24,564	194,619	185,821
Other current assets	1,090	33,651	247	22,443	3,803	24,030	55,572	140,836	203,337
Current portion of funds held by trustee	76	2,672	1	1,478	—	64	50,449	54,740	76,365
Total current assets	407,816	2,067,741	148,563	686,247	132,492	365,987	(519,961)	3,288,885	3,696,878
Assets whose use is limited:									
Management-designated cash and investments	523,467	1,350,622	47,682	1,204,626	570,946	218,945	1,014,570	4,930,858	4,601,153
Gift annuities, trusts, and other	360	16,366	2,351	27,886	—	15,116	31,725	93,804	53,954
Funds held by trustee	—	66,617	—	68,371	15,793	350	121,771	272,902	179,473
Assets whose use is limited, net	523,827	1,433,605	50,033	1,300,883	586,739	234,411	1,168,066	5,297,564	4,834,580
Property, plant, and equipment, net	552,020	3,065,950	94,018	1,030,286	69,003	1,025,488	744,095	6,580,860	6,622,566
Other assets	26,746	241,655	21,127	61,618	1,381	230,317	(9,876)	572,968	568,884
Total assets	$ 1,510,409	6,808,951	313,741	3,079,034	789,615	1,856,203	1,382,324	15,740,277	15,722,908
Liabilities and Net Assets									
Current liabilities:									
Current portion of long-term debt	$ 26,748	99,844	4,179	40,312	—	30,569	42,880	244,532	202,287
Master trust debt classified as short-term	—	—	—	—	—	—	137,500	137,500	12,500
Accounts payable	14,237	198,078	12,596	58,642	1,657	100,033	42,324	427,567	521,942
Accrued compensation	24,888	224,403	10,118	108,782	—	71,063	202,152	641,406	738,075
Payable to contractual agencies	5,742	51,047	122	3,812	2,952	8,168	32,808	104,651	151,778
Retirement plan obligations	—	—	—	—	—	—	190,278	190,278	185,517
Current portion of self-insurance liability	—	10,802	—	—	—	—	108,096	118,898	108,943
Other current liabilities	4,833	1,068,887	79,540	94,507	288,701	119,630	(1,192,900)	463,198	465,865
Total current liabilities	76,448	1,653,061	106,555	306,055	293,310	329,463	(436,862)	2,328,030	2,386,907
Long-term debt, net of current portion (1)	253,626	2,164,345	52,037	292,987	—	671,023	295,777	3,729,795	3,844,262
Other long-term liabilities	21,773	454,702	6,380	45,460	1,382	65,524	1,051,583	1,646,804	1,542,579
Total liabilities	351,847	4,272,108	164,972	644,502	294,692	1,066,010	910,498	7,704,629	7,773,748
Net assets:									
Unrestricted	1,145,988	2,409,856	142,933	2,326,791	494,923	639,972	426,316	7,586,779	7,537,626
Temporarily restricted	9,668	91,567	3,973	71,771	—	110,599	37,313	324,891	305,277
Permanently restricted	2,906	35,420	1,863	35,970	—	39,622	8,197	123,978	106,257
Total net assets	1,158,562	2,536,843	148,769	2,434,532	494,923	790,193	471,826	8,035,648	7,949,160
Total liabilities and net assets	$ 1,510,409	6,808,951	313,741	3,079,034	789,615	1,856,203	1,382,324	15,740,277	15,722,908

(1) The Obligated Group debt is joint and several for the Obligated Group members, however, the balance sheets of the individual entities only include their allocated portions.

See accompanying independent auditors' report.

PROVIDENCE HEALTH & SERVICES

Supplemental Schedule – Statement of Operations Information

December 31, 2015 (with combined totals for 2014)

(In thousands of dollars)

	Alaska	Washington	Montana	Oregon	Providence Plan Partners	Southern California	System office, eliminations, and other	2015 Total Health System	2014 Total Health System
Operating revenues:									
Net patient service revenues	$ 836,680	6,218,533	352,193	2,778,202	—	2,302,762	(519,254)	11,969,116	10,294,637
Provision for bad debts	(24,946)	(77,864)	(5,092)	(6,163)	—	(67,149)	(4,353)	(185,567)	(193,018)
Net patient service revenues less provision for bad debts	811,734	6,140,669	347,101	2,772,039	—	2,235,613	(523,607)	11,783,549	10,101,619
Premium and capitation revenues	—	181,793	—	96,362	1,330,926	253,155	—	1,862,236	1,682,968
Other revenues	51,996	314,105	26,771	263,283	79,623	113,959	(61,741)	787,996	696,390
Total operating revenues	863,730	6,636,567	373,872	3,131,684	1,410,549	2,602,727	(585,348)	14,433,781	12,480,977
Operating expenses:									
Salaries and wages	270,356	2,648,830	120,575	1,199,743	2,920	885,997	855,298	5,983,719	5,248,196
Employee benefits	24,395	368,935	10,693	117,004	17	80,075	756,584	1,357,703	1,220,078
Purchased healthcare	—	90,852	—	30,800	1,270,029	97,412	(444,074)	1,045,019	909,154
Professional fees	19,041	159,648	17,401	74,346	25,505	240,884	45,775	582,600	514,990
Supplies	111,607	1,015,985	73,416	518,569	659	318,183	33,586	2,072,005	1,792,707
Purchased services	53,791	407,247	38,484	154,627	146,166	166,111	138,763	1,105,189	977,247
Depreciation	54,600	263,881	11,263	107,851	2,098	70,778	120,066	630,537	676,357
Interest	14,725	86,479	2,689	5,994	—	32,617	10,976	153,480	155,343
Amortization	(12)	(1,045)	438	(325)	—	746	918	720	5,671
Other	24,528	498,491	14,186	194,265	38,759	293,719	177,045	1,240,993	762,082
Total operating expenses	573,031	5,539,303	289,145	2,402,874	1,486,153	2,186,522	1,694,937	14,171,965	12,261,825
Excess (deficit) of revenues over expenses from operations	290,699	1,097,264	84,727	728,810	(75,604)	416,205	(2,280,285)	261,816	219,152
Net nonoperating (losses) gains	(4,485)	(45,752)	226	(28,337)	7,855	(17,580)	(96,918)	(184,991)	552,270
Excess (deficit) of revenues over expenses	286,214	1,051,512	84,953	700,473	(67,749)	398,625	(2,377,203)	76,825	771,422
Net assets released from restriction for capital	109	7,027	(92)	2,618	—	9,622	1,088	20,372	13,646
Change in noncontrolling interests in consolidated joint ventures	(73)	(397)	—	(804)	—	(819)	1,695	(398)	584
Pension related changes	—	(19,156)	—	1,263	—	—	(9,522)	(27,415)	(249,011)
Interdivision transfers	(171,911)	(954,602)	(79,776)	(685,019)	—	(480,719)	2,372,027	—	—
Contributions, grants, and other	(3,497)	(8,491)	10	(2,769)	—	(4,073)	(1,411)	(20,231)	(8,639)
Increase (decrease) in unrestricted net assets	$ 110,842	75,893	5,095	15,762	(67,749)	(77,364)	(13,326)	49,153	528,002

See accompanying independent auditors' report.

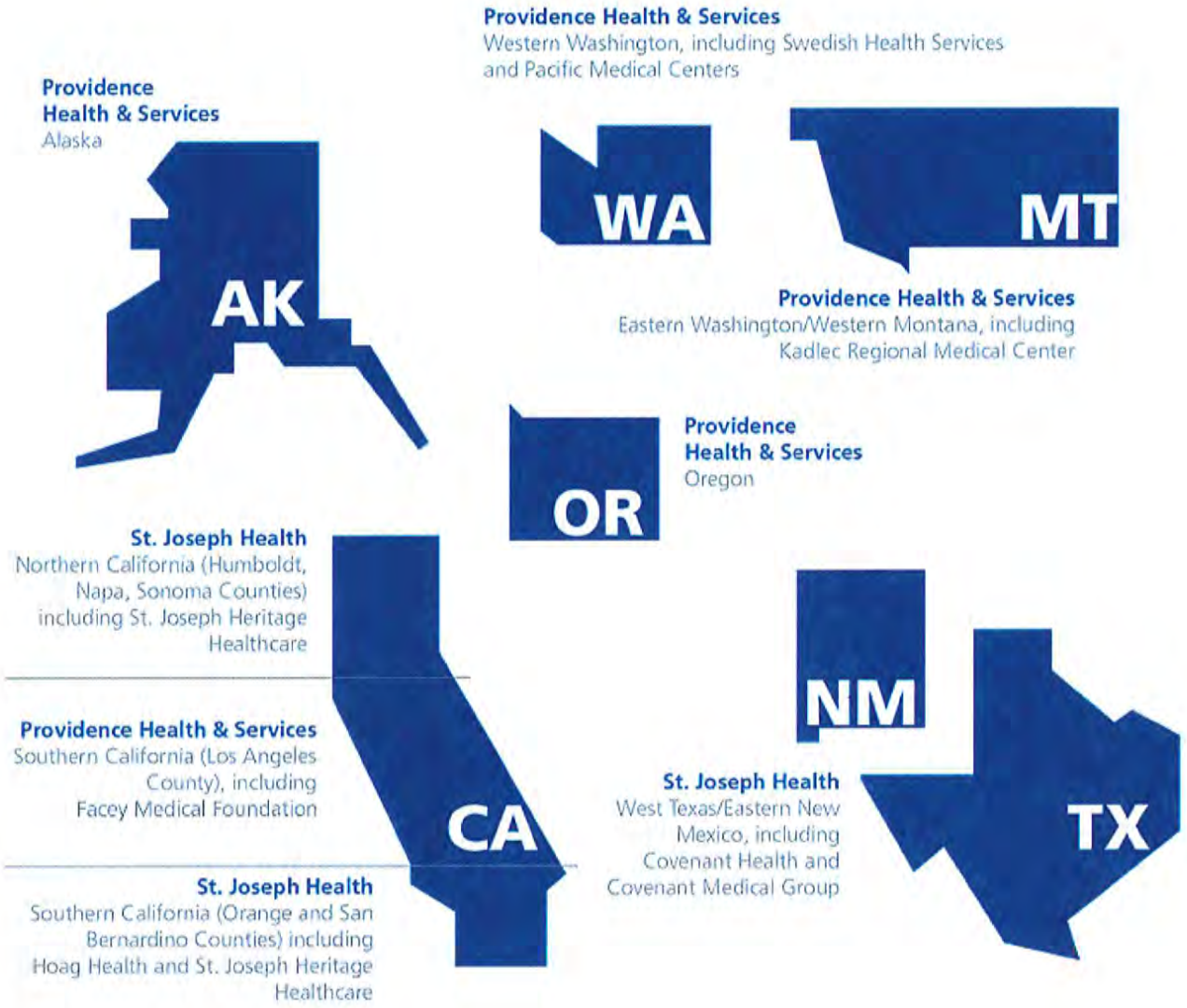
Providence St. Joseph Health

Management's Discussion and Analysis of Financial Condition and Results of Operations

Year ended December 31, 2016

About Providence St. Joseph Health

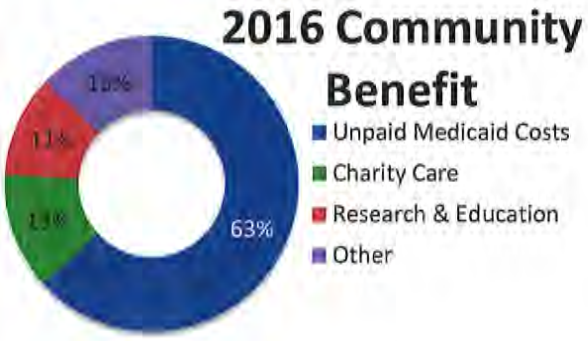
Effective July 1, 2016, Providence Health & Services and St. Joseph Health came together to serve more people in a partnership that joins two remarkable organizations with rich heritages. We are now connected by a new parent organization, Providence St. Joseph Health. Together, over 100,000 of our caregivers (employees) now serve in 50 hospitals, over 800 clinics and a comprehensive range of health and social services across Alaska, California, Montana, New Mexico, Oregon, Texas and Washington. All hospitals and other ministries will maintain their current names and identities. This parent structure allows our family of diverse organizations to work together to meet the needs of our communities both today and into the future.



Investing in our communities to improve health and increase access

Providence St. Joseph Health provided $1.6 billion in community benefit in 2016. Through programs and donations, health education, free care, medical research and more, our community benefit investments fulfill unmet needs in communities we serve across seven states.

In an environment of decreased reimbursement for government-sponsored medical care, community benefit spending related to the unpaid costs of Medicaid was more than $1 billion through the fourth quarter of 2016. Answering the call of our Mission to care for everyone, regardless of their ability to pay, we offered more than $210 million in free and discounted care for those in need.



Advocating for important health and social programs

We believe health care is a basic human right and are committed to expanded coverage that gives access to affordable care for all. With a special focus on serving those who are poor and vulnerable, we advocate for policies that will improve the health of entire communities and further facilitate innovation in care and payment models. During 2016 we helped advance legislation that supports primary care, care management and cognitive services, telehealth services and new care and payment models in Medicaid and Medicare.

Our commitment to mental health

In honor of the 143,000 caregivers, physicians, volunteers and board members who make up Providence St. Joseph Health, the System donated $1.43 million to organizations focused on improving awareness and care for those with mental illness. Donations were made to the Mental Health First Aid program, sponsored by the National Council for Behavioral Health, and the National Alliance on Mental Illness Family-to-Family program. The funds will support the training of more than 50,000 people living and working in Providence St. Joseph Health communities on skills such as understanding the signs of mental illness.

We also announced the Institute for Mental Health and Wellness' first chief executive, Tyler Norris, MDiv. The institute was founded as part of a larger commitment by Providence St. Joseph Health to address the growing mental health crisis in the U.S. The System made an initial seed endowment of $100 million to support advances in behavioral health, including awareness, diagnosis and treatment. In his new role, Norris will shape the institute's vision and strategic direction through community-based collaborations and partnerships.

Leading dynamic change through innovation

Extending relationships between episodes of care

Providence St. Joseph Health's Digital and Innovation Division aims to build meaningful relationships and serve as valuable partners in health. The group tests consumer innovations that are adjacent to our health care services and improve overall community health. Through these innovations, we decrease our population risk by creating a continuous relationship with consumers between episodes of care.

We are currently running new services in women's health (Circle™) and senior services (Optimal Aging™). The Circle™ women and children's app is built on a personalization platform which provides trusted answers to frequently asked questions about maternal and pediatric health. This service enables families to connect to the System and community resources conveniently, and is deploying across the System in 2017. Optimal Aging™ provides seniors affordable access to transportation, meals, home care, home maintenance and social connections. This service fulfills goals to support seniors' day-to-day living, improve the safety of their homes, and provide trusted planning and advice about aging optimally. Optimal Aging™ is currently is available in King and Snohomish counties, Wash., and looks forward to expanding to Portland, Ore. in 2017.

Introduction to Management's Discussion and Analysis

Management's discussion and analysis provides additional narrative explanation of the financial condition, operational results and cash flow of the System to increase understanding of the combined financial statements. The following information should be read in conjunction with the audited combined financial statements and related footnotes.

System overview

Effective July 1, 2016, Providence St. Joseph Health, a Washington nonprofit corporation, became the sole member of both Providence Health & Services, a Washington nonprofit corporation, and St. Joseph Health, a California nonprofit public benefit corporation, each of which were a multi-state health system, creating one of the largest health care systems in the United States. The System, headquartered in Renton, Washington, is structured with a centralized operating model and governed by a co-sponsorship council made up of members of its two sponsoring ministries, Providence Ministries and St. Joseph Health Ministry.

Providence Health & Services has a fiscal year ending December 31, and St. Joseph Health has a fiscal year ending June 30. The System has adopted a fiscal year ending December 31. To enable certain financial results to be presented on a consistent basis, notwithstanding the difference in fiscal years, unaudited pro forma combined financial results of the System are presented for the twelve-month periods ended December 31, 2016 and 2015.

Financial performance

The results discussed in this document are presented on a pro forma basis for the System. Data was derived by combining the consolidated year-to-date results of Providence Health & Services and St. Joseph Health assuming that operations of the two organizations were combined as of January 1, 2015. Certain immaterial adjustments have been made to conform financial statement presentations. Pro forma data includes the impact of affiliation related transactions, such as asset write-ups and the related amortization/depreciation of these assets, prior to the affiliation date of July 1, 2016. Management believes this pro forma data is the most useful presentation for evaluating and discussing current year operations in comparison to the prior year.

Year-to-date results

Balance Sheet	Providence St. Joseph Health (Pro Forma)			
PRESENTED IN MILLIONS	12-31-16	12-31-2015	12 MONTH CHANGE	CHANGE %
Current Assets:				
Cash and Cash Equivalents	782	885	(103)	(12%)
Short-term Management Designated Investments	875	1,139	(264)	(23%)
Accounts Receivable, Net	2,206	2,153	53	2%
Other Current Assets	1,449	1,047	402	38%
Current Portion of Funds Held by Trustee	109	55	54	98%
Total Current Assets	**5,421**	**5,279**	**142**	**3%**
Assets Whose Use is Limited:				
Management Designated Cash and Investments	8,091	7,361	730	10%
Funds Held by Trustee, Gift, Annuity, and Other	641	512	129	25%
Total Assets Whose Use is Limited	**8,731**	**7,873**	**858**	**11%**
Property, Plant & Equipment	**11,022**	**10,477**	**545**	**5%**
Total Other Assets	**1,118**	**1,220**	**(102)**	**(8%)**
Total Assets	**26,292**	**24,849**	**1,443**	**6%**
Current Liabilities:				
Short-term Debt and Current Portion of Long-term Debt	353	471	(118)	(25%)
Accounts Payable	584	555	29	5%
Accrued Compensation	1,104	924	180	19%
Other Current Liabilities	1,911	1,446	465	32%
Total Current Liabilities	**3,952**	**3,396**	**556**	**16%**
Long-Term Debt, Net of Current Portion	6,396	6,009	387	6%
Other Long-term Liabilities	2,149	2,039	110	5%
Total Liabilities	**12,497**	**11,444**	**1,053**	**9%**
Net Assets:				
Unrestricted	12,759	12,539	220	2%
Restricted Net Assets	1,035	866	169	20%
Total Net Assets	**13,795**	**13,405**	**390**	**3%**
Total Liabilities and Net Assets	**26,292**	**24,849**	**1,443**	**6%**

Statement of Operations	Providence St. Joseph Health (Pro Forma)			
DATA PRESENTED YEAR TO DATE; $ FIGURES PRESENTED IN MILLIONS	2016 ACTUAL	2015 ACTUAL	VARIANCE	VARIANCE %
Net Patient Revenue	17,296	16,575	721	4%
Premium and Capitation Revenue	3,773	3,116	657	21%
Other Revenue	1,088	1,050	38	4%
Total Revenue	**22,157**	**20,741**	**1,416**	**7%**
Salaries and Wages	8,926	8,145	781	10%
Depreciation	1,036	997	39	4%
Interest and Amortization	265	260	5	2%
Other Expenses	12,185	11,058	1,127	10%
Total Operating Expenses	**22,412**	**20,460**	**1,952**	**10%**
Excess of Revenues Over Expenses from Operations	**(255)**	**281**	**(536)**	**(191%)**
Net Nonoperating Gains (Losses)	5,485	(248)	5,733	(2312%)
Excess of Revenues Over Expenses	**5,230**	**33**	**5,197**	**15748%**
Operating EBIDA	**1,046**	**1,537**	**(491)**	**(32%)**

Key Financial Indicators	Providence St. Joseph Health (Pro Forma)			
DATA PRESENTED YEAR TO DATE; $ FIGURES PRESENTED IN MILLIONS	2016 ACTUAL	2015 ACTUAL	YTD VAR	YTD VAR %
Operating Margin %	(1.2)	1.4	(2.6)	(186%)
Operating EBIDA Margin %	4.7	7.4	(2.7)	(36%)
Total Community Benefit	1,632	1,445	187	13%
Net Service Revenue / Case Mix Adj Admits (whole value)	11,817	12,118	(301)	(2%)
Expense/ Case Mix Adj Admits	11,976	11,932	44	0%
FTEs (presented in thousands)	102	96	6	6%

Lower reimbursement for services from changes in payor mix, payment rates and procedure mix remains the most significant challenge for the System. While volumes have continued to grow in comparison to the prior year, this growth has correlated with a higher percentage of Medicaid patients and increases in acuity levels as measured by case mix index. In addition to reimbursement challenges, the System has been facing increasing labor and supply costs. A competitive labor market has led to higher wage costs and increased vacancy, resulting in greater utilization and rates of agency staffing. These industry challenges have exerted financial pressure on the System, resulting in a year-to-date operating loss of $255 million.

Net income included a net gain of $5.1 billion in 2016 from the affiliation inherent contribution and one-time debt refinancing, which was primarily driven by the St. Joseph Health affiliation and subsequent debt restructuring. The inherent contribution is the result of the affiliation being a non-cash transaction. With the impact of the affiliation inherent contribution and debt refinancing removed, year-to-date net income was $122 million, up from $33 million in the prior year. The increase in adjusted net income was primarily the result of current year investment gains of $493 million, partially offset by operating losses and innovation related expenses.

Volumes

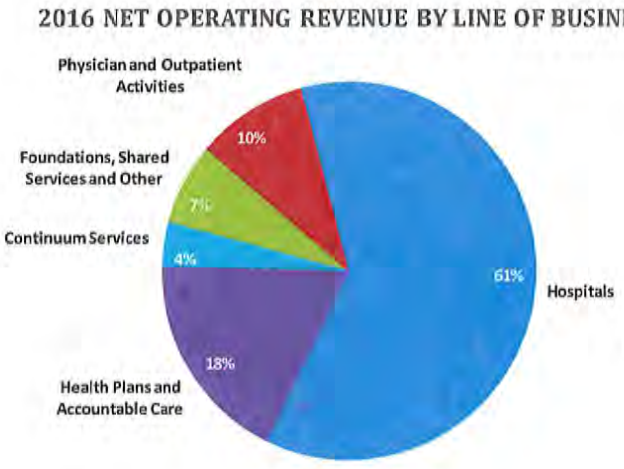
Key Volume Indicators	Providence St. Joseph Health (Pro Forma)			
DATA PRESENTED YEAR TO DATE; IN THOUSANDS UNLESS NOTED	2016 ACTUAL	2015 ACTUAL	YTD VAR	YTD VAR %
Inpatient Admissions	526	519	7	1%
Acute Adjusted Admissions	989	957	32	3%
Outpatient Visits	24,352	22,875	1,477	6%
Total Surgeries	567	545	22	4%
Providence Health Plan Members	639	513	126	25%

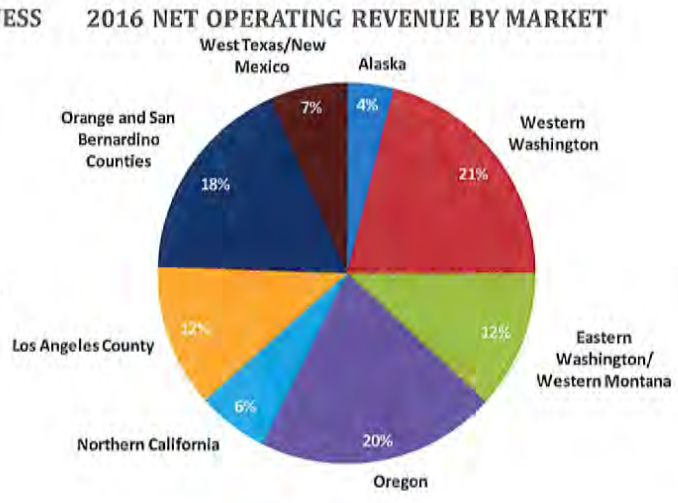
While the System has experienced volumes growth in 2016, trends in this growth have been highly influenced by the effects of the Affordable Care Act. Specifically, growth has been highest amongst Medicaid patients with an overall higher acuity level, which require additional resources to serve. Additionally, the System has experienced increases in ambulatory services at a rate that largely outpaced growth in acute and inpatient services. This increase in physician visits was attributed to employment of new physicians and advanced care practitioners in 2016, in addition to increased panel sizes for clinicians hired in 2015. Clinic expansion also continued through our partnership with Walgreens, opening 25 new clinics in 2016.

Surgery volumes also experienced higher growth in the outpatient setting as compared to the inpatient setting. Year-to-date inpatient surgeries increased 1 percent, while outpatient increased 6 percent as compared to the same period of 2015. Surgery increases are partially attributed to an exclusive contract with Group Health in Washington to provide inpatient services as well as improvements in integrated care networks.

The Providence Health Plan enrollment growth has continued in 2016 through an expansion of services and coverage. Year-to-date connected lives member months, a measure of coverage for insured members, increased from 6.1 million member months in 2015 to 7.5 million member months in 2016.

Operating Revenue





Year-to-date operating revenue of $22.2 billion was 7 percent greater than the prior year. Approximately half of the increase was driven by a 21 percent rise in capitated and premium revenue. Total premium revenue of $2.8 billion was 41 percent higher than prior year as health plan member enrollment increased in 2016. Premium revenue grew at a slower rate than membership as a result of changes in business line mix. Capitated and premium revenue now represents 17 percent of the System's total operating revenue as compared to 15 percent in the prior year.

Patient service revenue grew by 4 percent which was less than the 6 percent volume increase as measured by case mix adjusted admissions. The lower service revenue growth was driven by changes in payor mix, payment rates and procedure mix. While higher acuity as measured by case mix index generally results in higher reimbursement, related increases in revenue were offset by unfavorable shifts in payor mix. Medicaid and Medicare revenues as a percentage of total net revenue grew by 1 percent to become 48 percent of the acute business.

Payor Mix -Net Patient Revenue	Providence St. Joseph Health (Pro Forma)			
DATA PRESENTED YEAR TO DATE:	2016 ACTUAL	2015 ACTUAL	YTD VAR	YTD VAR %
Commercial	51%	51%	0%	0%
Medicare	32%	31%	1%	3%
Medicaid	16%	16%	0%	0%
Self-pay	2%	1%	1%	100%
Other	(1%)	1%	(2%)	0%

Operating expenses

Year-to-date operating expenses grew by 10 percent over the prior year as a result of the costs from higher volumes, patient acuity levels, and rates to serve those volumes. Expenses from labor and supplies grew at a higher rate than volumes due to inflation and productivity deterioration, while the increase in purchased health care services correlated with higher health plan member enrollment. Year-to-date salaries and benefits grew by 7 percent over prior year. This unfavorable trend was driven by full-time equivalent (FTE) growth of 6 percent and rate growth of 3 percent from a competitive labor market.

Supply expense as a percentage of net service revenue is 6 percent higher than the prior year, representing a $299 million increase. This increase was primarily driven by growth of specialty, retail, ambulatory, and infusion center pharmacy costs. Overall supply costs have increased 10 percent over the prior year, primarily driven by pharmacy costs that have increased 14 percent over the same period.

Year-to-date purchased healthcare expenses were 51 percent higher than the prior year as a result of growth in enrolled members of the Providence Health Plan over the prior year.

Non-Operating Income

Non-operating income included a net gain of $5.1 billion in 2016 from the affiliation inherent contribution and one-time debt refinancing, which was primarily driven by the St. Joseph Health affiliation and subsequent debt restructuring. With the impact of the affiliation inherent contribution and debt refinancing removed, year-to-date non-operating gains were $377 million. This amount was driven by year-to-date

investment gains of $493 million in 2016, compared to year-to-date losses of $156 million in 2015. Investment income was partially offset by growth in other non-operating expenses such as pension settlement costs and innovation investments, which were $28 million and $44 million through December, respectively.

Capital and liquidity

Liquidity Indicators	Providence St. Joseph Health (Pro Forma)			
DATA PRESENTED YEAR TO DATE $ FIGURES PRESENTED IN MILLIONS	12-31-16 ACTUAL	12-31-15 ACTUAL	YTD VAR	YTD VAR %
Accounts Receivable Days	45	46	(1)	(2%)
Days of Cash on Hand	168	177	(9)	(5%)
Long-term Debt to Capitalization	33.9	32.9	1.0	3%
Debt Service Coverage	1.8	3.2	(1.4)	(44%)
Cash to Debt Ratio	148.8	152.7	(3.9)	(3%)
Cash to Total Net Asset Ratio	0.76	0.75	0.01	1%

Unrestricted cash reserves totaled $9.7 billion as of December 31, 2016, up from $9.2 billion as of December 31, 2015. The increase was driven by cash generated from operations, investment gains and proceeds from financing transactions, partially offset by payments related to pension obligations, debt, and capital expenditures. Despite cash growth from prior year, higher costs associated with servicing additional volumes resulted in an overall four day decline in days of cash on hand.

In the third quarter of 2016, the System initiated a series of bond offerings which included the refinancing of certain tax-exempt bonds held by St. Joseph Health prior to the affiliation, executing on a plan to create a single obligated group. The aggregate offering included $448 million of California tax-exempt fixed rate bonds, $286 million of California tax-exempt fixed rate put bonds, $680 million of taxable fixed rate bonds, $100 million of taxable variable rate bonds and a few privately placed direct purchases with staggered tender dates. The offering unified the debt structures of the System at a more favorable cost of capital. While retirement of the existing debt resulted in $60 million in one-time losses on extinguishment of debt, the overall transaction will generate more than $25 million in annual interest savings.

Prior to the debt offering but subsequent to the affiliation of Providence Health & Services and St. Joseph Health, the three national credit rating agencies conducted their annual review process of the newly formed Providence St. Joseph Health. The agencies issued the following credit ratings:

- Fitch: "AA-"
- Standard and Poor's: "AA-"
- Moody's: "Aa3"

All three agencies issued a stable outlook based on the System's favorable enterprise profile and strong financial position. As further evidence of the System's financial strength, the recent bond offering demonstrated ample demand throughout the pricing process from investors.

Subsequent Events

Effective February 23, 2017 the Health System and Catholic Health Initiatives entered into an agreement with Laboratory Corporation of America to sell all of its ownership interest in Pathology Associates Medical Laboratories and its affiliated joint ventures.

In October 2016 Providence St. Joseph Health reached a tentative settlement to resolve an outstanding law suit regarding the Church Plan designation of the Providence Cash Balance Retirement Plan (the Plan). Terms of the settlement included a commitment to contribute $350M over a seven year period and payment of up to $6.5M in plaintiff attorney fees. As a condition of the settlement the Health System will retain the Church Plan designation of the Plan. The settlement is in the process of court approval and class notification. If approved, the settlement will not have a material adverse effect on financial condition of Providence St. Joseph Health.

The System versus St. Joseph Health financial performance crosswalk

As noted previously, the results discussed in this document are presented on a pro forma basis for the System. The tables below represent a comparison of the combined pro forma data for 2016 and 2015 versus audited results of the System, which includes St. Joseph Health financial results from the effective date of the affiliation of July 1, 2016.

Statement of Operations	2016	
DATA PRESENTED YEAR TO DATE; $ FIGURES PRESENTED IN MILLIONS	Providence St. Joseph Health (Pro Forma)	Providence St. Joseph Health Audited Results
Net Patient Revenue	17,296	14,769
Premium and Capitation Revenue	3,773	3,104
Other Revenue	1,088	1,005
Total Revenue	**22,157**	**18,878**
Salaries and Wages	8,926	7,788
Depreciation	1,036	851
Interest and Amortization	265	215
Other Expenses	12,185	10,274
Total Operating Expenses	**22,412**	**19,128**
Excess of Revenues Over Expenses from Operations	**(255)**	**(250)**
Net Nonoperating Gains (Losses)	5,485	5,480
Excess of Revenues Over Expenses	**5,230**	**5,230**

Statement of Operations	2015	
DATA PRESENTED YEAR TO DATE; $ FIGURES PRESENTED IN MILLIONS	Providence St. Joseph Health (Pro Forma)	Providence St. Joseph Health Audited Results
Net Patient Revenue	16,575	11,784
Premium and Capitation Revenue	3,116	1,862
Other Revenue	1,050	788
Total Revenue	**20,741**	**14,434**
Salaries and Wages	8,145	5,984
Depreciation	997	631
Interest and Amortization	260	154
Other Expenses	11,058	7,403
Total Operating Expenses	**20,460**	**14,172**
Excess of Revenues Over Expenses from Operations	**281**	**262**
Net Nonoperating Gains (Losses)	(248)	(185)
Excess of Revenues Over Expenses	**33**	**77**

KPMG

PROVIDENCE ST. JOSEPH HEALTH

Combined Financial Statements

December 31, 2016 and 2015

(With Independent Auditors' Report Thereon)

KPMG LLP
Suite 2900
1918 Eighth Avenue
Seattle, WA 98101

Independent Auditors' Report

The Board of Directors
Providence St. Joseph Health:

We have audited the accompanying combined financial statements of Providence St. Joseph Health, which comprise the combined balance sheets as of December 31, 2016 and 2015, and the related combined statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the combined financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these combined financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of combined financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these combined financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the combined financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the combined financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the combined financial statements, whether due to fraud or error. In making those risk assessments, the auditors consider internal control relevant to the entity's preparation and fair presentation of the combined financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the combined financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the combined financial statements referred to above present fairly, in all material respects, the financial position of Providence St. Joseph Health as of December 31, 2016 and 2015, and the results of its operations and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

KPMG LLP

Seattle, Washington
March 22, 2017

PROVIDENCE ST. JOSEPH HEALTH

Combined Balance Sheets

December 31, 2016 and 2015

(In millions of dollars)

Assets		2016	2015
Current assets:			
Cash and cash equivalents	$	1,000	729
Accounts receivable, less allowance for bad debts of $271 in 2016 and $344 in 2015		2,206	1,570
Supplies inventory		279	195
Other current assets		1,169	540
Current portion of assets whose use is limited		766	256
Total current assets		5,420	3,290
Assets whose use is limited		8,731	5,298
Property, plant, and equipment, net		11,022	6,581
Other assets		1,118	540
Total assets	$	26,291	15,709
Current liabilities:			
Current portion of long-term debt	$	200	245
Master trust debt classified as short-term		153	138
Accounts payable		584	428
Accrued compensation		1,104	641
Other current liabilities		1,911	878
Total current liabilities		3,952	2,330
Long-term debt, net of current portion		6,396	3,696
Pension benefit obligation		1,120	1,064
Other liabilities		1,027	583
Total liabilities		12,495	7,673
Net assets:			
Unrestricted:			
Controlling interest		12,560	7,542
Noncontrolling interest		200	45
Temporarily restricted		816	325
Permanently restricted		220	124
Total net assets		13,796	8,036
Total liabilities and net assets	$	26,291	15,709

See accompanying notes to combined financial statements.

PROVIDENCE ST. JOSEPH HEALTH

Combined Statements of Operations

Years ended December 31, 2016 and 2015

(In millions of dollars)

	2016	2015
Operating revenues:		
Net patient service revenues	$ 14,972	11,969
Provision for bad debts	(203)	(186)
Net patient service revenues less provision for bad debts	14,769	11,783
Premium revenues	2,240	1,464
Capitation revenues	865	399
Other revenues	1,005	788
Total operating revenues	18,879	14,434
Operating expenses:		
Salaries and benefits	9,599	7,341
Supplies	2,788	2,072
Purchased healthcare services	1,917	1,045
Interest, depreciation, and amortization	1,066	785
Purchased services, professional fees, and other	3,758	2,929
Total operating expenses	19,128	14,172
(Deficit) excess of revenues over expenses from operations	(249)	262
Net nonoperating gains (losses):		
Contributions from affiliations	5,167	—
Loss on extinguishment of debt	(60)	—
Investment income (losses), net	403	(114)
Other	(30)	(71)
Total net nonoperating gains (losses)	5,480	(185)
Excess of revenues over expenses	$ 5,231	77

See accompanying notes to combined financial statements.

PROVIDENCE ST. JOSEPH HEALTH

Combined Statements of Changes in Net Assets

Years ended December 31, 2016 and 2015

(In millions of dollars)

	Unrestricted: controlling interest	Unrestricted: noncontrolling interest	Temporarily restricted	Permanently restricted	Total net assets
Balance, December 31, 2014	$ 7,492	45	305	106	7,948
Excess of revenues over expenses	72	5	—	—	77
Contributions, grants, and other	(15)	(5)	89	18	87
Net assets released from restriction	20	—	(69)	—	(49)
Pension related changes	(27)	—	—	—	(27)
Increase in net assets	50	—	20	18	88
Balance, December 31, 2015	7,542	45	325	124	8,036
Excess of revenues over expenses	5,093	138	—	—	5,231
Restricted contributions from affiliations	—	—	405	91	496
Contributions, grants, and other	(13)	17	145	5	154
Net assets released from restriction	19	—	(59)	—	(40)
Pension related changes	(81)	—	—	—	(81)
Increase in net assets	5,018	155	491	96	5,760
Balance, December 31, 2016	$ 12,560	200	816	220	13,796

See accompanying notes to combined financial statements.

PROVIDENCE ST. JOSEPH HEALTH

Combined Statements of Cash Flows

Years ended December 31, 2016 and 2015

(In millions of dollars)

	2016	2015
Cash flows from operating activities:		
Increase in net assets	$ 5,760	88
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Contributions from affiliations	(5,663)	—
Depreciation and amortization	860	631
Provision for bad debt	203	186
Loss on extinguishment of debt	60	—
Restricted contributions and investment income received	(150)	(113)
Net realized and unrealized (gains) losses on investments	(316)	179
Changes in certain current assets and current liabilities	13	(485)
Change in certain long-term assets and liabilities	26	111
Net cash provided by operating activities	793	597
Cash flows from investing activities:		
Property, plant, and equipment additions	(967)	(637)
Sales (purchases) of trading securities, net	68	(242)
Purchases of alternative investments and commingled funds	(466)	(360)
Proceeds from sales of alternative investments and commingled funds	153	44
Cash acquired through affiliations	367	—
Other investing activities	49	(77)
Net cash used in investing activities	(796)	(1,272)
Cash flows from financing activities:		
Proceeds from restricted contributions and restricted income	150	113
Debt borrowings	3,606	453
Debt payments	(3,474)	(400)
Other financing activities	(8)	1
Net cash provided by financing activities	274	167
Increase (decrease) in cash and cash equivalents	271	(508)
Cash and cash equivalents, beginning of year	729	1,237
Cash and cash equivalents, end of year	$ 1,000	729
Supplemental disclosure of cash flow information:		
Cash paid for interest (net of amounts capitalized)	$ 191	142

See accompanying notes to combined financial statements.

(1) Basis of Presentation and Significant Accounting Policies

(a) Reporting Entity

Providence Health & Services (PHS), a Washington nonprofit corporation, is a Catholic healthcare system sponsored by the public juridic person, Providence Ministries.

Effective July 1, 2016, Providence St. Joseph Health (the Health System), a Washington nonprofit corporation, became the sole corporate member of both PHS and St. Joseph Health System (SJHS). SJHS, a California nonprofit public benefit corporation, is a Catholic healthcare system sponsored by the public juridic person, St. Joseph Health Ministry. Due to the circumstances of the business combination between PHS and SJHS, through the alignment under the Health System, the transaction qualified for acquisition accounting with PHS as the acquirer of SJHS.

The Health System seeks to improve the health of the communities it serves, especially the poor and vulnerable. The Health System operations includes 50 hospitals and a comprehensive range of services provided across Alaska, California, Montana, New Mexico, Oregon, Texas, and Washington. The Health System also provides population health management through various affiliated licensed insurers and other risk-bearing entities.

The Health System has filed for an Internal Revenue Service determination letter and believes that it is exempt from federal income tax as a charitable organization under Section 501(c)(3). PHS, SJHS, and substantially all of the various corporations within the Health System have been granted exemptions from federal income tax as charitable organizations under Section 501(c)(3) of the Internal Revenue Code.

The accompanying combined balance sheets and related combined statements of operations, statements of changes in nets assets, and statements of cash flows reflect the PHS financial position and results of operations as of and for the year ended December 31, 2015 and the Health System financial position and results of operations as of and for the year ended December 31, 2016. The Health System results of operations for the year ended December 31, 2016 include twelve months of results of operations for PHS and six months of results of operations for SJHS.

(b) Basis of Presentation

The accompanying combined financial statements of the Health System were prepared in accordance with U.S. generally accepted accounting principles and include the assets, liabilities, revenues, and expenses of all wholly owned affiliates, majority-owned affiliates over which the Health System exercises control, and, when applicable, entities in which the Health System has a controlling financial interest.

Intercompany balances and transactions have been eliminated in combination.

(Continued)

(c) Performance Indicator

The performance indicator is the excess of revenues over expenses. Changes in unrestricted net assets that are excluded from the performance indicator include net assets released from restriction for the purchase of property plant and equipment, certain changes in funded status of pension and other postretirement benefit plans, restricted contributions from affiliations, net changes in noncontrolling interests in combined joint ventures, and certain other activities.

(d) Operating and Nonoperating Activities

The Health System's primary mission is to meet the healthcare needs in its market areas through a broad range of general and specialized healthcare services, including inpatient acute care, outpatient services, physician services, long-term care, population health management, and other healthcare and health insurance services. Activities directly associated with the furtherance of this mission are considered to be operating activities. Other activities that result in gains or losses peripheral to the Health System's primary mission are considered to be nonoperating. Nonoperating activities include investment earnings, gains or losses from debt extinguishment, contributions from affiliations, and certain other activities.

(e) Use of Estimates and Assumptions

The preparation of the combined financial statements in conformity with U.S. generally accepted accounting principles requires the use of estimates and assumptions that affect the reported amounts of assets and liabilities and the reported amounts of revenues and expenses during the reporting periods. Significant estimates and assumptions are used for, but not limited to: (1) allowance for contractual revenue adjustments; (2) allowance for doubtful accounts; (3) fair value of acquired assets and assumed liabilities in business combinations; (4) useful lives of depreciable and amortizable assets; (5) fair value of investments; (6) reserves for self-insured healthcare plans; (7) reserves for professional, workers' compensation and general insurance liability risks; (8) reserves for underwritten prepaid healthcare contracts including managed care contracts and capitation agreements, and (9) contingency and litigation reserves.

The accounting estimates used in the preparation of the combined financial statements will change as new events occur, additional information is obtained or the operating environment changes. Assumptions and the related estimates are updated on an ongoing basis and external experts may be employed to assist in the evaluation, as considered necessary. Actual results could materially differ from those estimates.

(f) Cash and Cash Equivalents

Cash and cash equivalents include highly liquid investments with an original or remaining maturity of three months or less when acquired.

(g) Supplies Inventory

Supplies inventory is stated at the lower of cost (first-in, first-out) or market.

(In millions of dollars)

(h) Property, Plant, and Equipment

Property, plant, and equipment are stated at cost. Improvements and replacements of plant and equipment are capitalized, maintenance and repairs are expensed. The provision for depreciation is determined by the straight-line method, which allocates the cost of tangible property equally over its estimated useful life or lease term. Impairment of property, plant, and equipment is assessed when there is evidence that events or changes in circumstances have made recovery of the net carrying value of assets unlikely.

Interest capitalized on amounts expended during construction is a component of the cost of additions to be allocated to future periods through the provision for depreciation. Capitalization of interest ceases when the addition is substantially complete and ready for its intended use.

Property, plant, and equipment and the total accumulated depreciation at December 31, 2016 and 2015 are shown below:

	Approximate useful life (years)	2016	2015
Land	—	$ 1,419	757
Buildings and improvements	5–60	8,638	5,834
Equipment:			
Fixed	5–25	1,127	1,056
Major movable and minor	3–20	5,466	4,406
Rental property	15–40	941	914
Construction in progress	—	888	275
		18,479	13,242
Less accumulated depreciation		7,457	6,661
Property, plant, and equipment, net		$ 11,022	6,581

Construction in progress primarily represents renewal and replacement of various facilities in the Health System's operating divisions, as well as costs capitalized to software development.

(i) Other Assets

Other assets primarily consist of investments in nonconsolidated joint ventures, beneficial interest in noncontrolled foundations, notes receivable, goodwill, and other intangible assets.

(Continued)

(In millions of dollars)

Other assets at December 31, 2016 and 2015 are as follows:

	2016	2015
Investment in nonconsolidated joint ventures	$ 285	141
Intangible assets	253	58
Goodwill	158	112
Beneficial interest in noncontrolled foundations	146	128
Other	276	101
Total other assets	$ 1,118	540

Goodwill is recorded as the excess of cost over fair value of the acquired net assets. Indefinite-lived intangible assets are recorded at fair value using various methods depending on the nature of the intangible asset. Both goodwill and indefinite-lived intangible assets are tested at least annually for impairment. Definite-lived intangible assets are amortized using the straight-line method over the estimated useful lives of the assets.

The Health System recorded impairment of $36 and $0 during the years ended December 31, 2016 and 2015, respectively. The goodwill impairment recognized during the year ended December 31, 2016 was attributable to medical foundation acquisitions made in previous years.

(j) Investments Including Assets Whose Use Is Limited

The Health System has designated all of its investments in debt and equity securities, hedge funds, and commingled funds as trading securities. These investments are reported on the combined balance sheets at fair value on a trade-date basis.

Investment sales and purchases initiated prior to and settled subsequent to the combined balance sheet date result in amounts due from and to brokers. As of December 31, 2016, the Health System recorded a receivable of $136 for investments sold but not settled and a payable of $375 for investments purchased but not settled in other current assets and other current liabilities, respectively, in the accompanying combined balance sheets.

Assets whose use is limited primarily include assets held by trustees under indenture agreements, self-insurance funds, funds held for the payment of health plan medical claims and other statutory reserve requirements, assets held by related foundations, and designated assets set aside by management of the Health System for future capital improvements and other purposes, over which management retains control.

(Continued)

(In millions of dollars)

Investment income from investments including assets whose use is limited are included in net nonoperating gains (losses) and are comprised of the following for the years ended December 31, 2016 and 2015:

		2016	2015
Interest and dividend income	$	87	65
Net realized (losses) gains on sale of trading securities		(9)	25
Change in net unrealized gains (losses) on trading securities		325	(204)
Investment income (losses), net	$	403	(114)

(k) Derivative Instruments

The Health System uses derivative financial instruments (interest rate swaps) to manage its interest rate exposure and overall cost of borrowing. As of December 31, 2016, the Health System has interest rate swap contracts with a total current notional amount totaling $480 with varying expiration dates. The Health System had no interest rate swap contracts as of December 31, 2015.

Derivative financial instruments are recorded at fair value taking into consideration the Health System's and the counterparties' nonperformance risk. As of December 31, 2016, the fair value of outstanding interest rate swaps was in a net liability position of $104 and is included in other liabilities in the accompanying combined balance sheets. As of December 31, 2016, collateral posted in connection with the outstanding swap agreements was $5 and is included in other assets in the accompanying combined balance sheets.

The interest rate swap agreements do not meet the criteria for hedge accounting and all changes in the valuation are recognized as a component of net nonoperating gains (losses) in the accompanying combined statements of operations. Settlements related to these agreements are recognized as a component of interest expense in the accompanying combined statements of operations. For the year ended December 31, 2016, the change in valuation was a $52 gain and settlements recognized as a component of interest expense were $7.

(Continued)

(In millions of dollars)

The Health System also allows certain investment managers to use derivative financial instruments (futures and forward currency contracts) to manage interest rate risk related to the Health System's fixed-income holdings. The investment managers have executed master netting arrangements with the counterparties of the futures and forward currency purchase and sale contracts whereby the financial instruments held by the same counterparty are legally offset as the instruments are settled. The following table presents gross investment derivative assets and liabilities reported on a net basis at fair value included in assets whose use is limited in the combined balance sheets:

		2016	2015
Derivative assets:			
Futures contracts	$	394	405
Forward currency and other contracts		80	42
Total derivative assets	$	474	447
Derivative liabilities:			
Futures contracts	$	(394)	(405)
Forward currency and other contracts		(76)	(42)
Total derivative liabilities	$	(470)	(447)

(l) Self-Insurance Liabilities

The Health System has established self-insurance programs for professional and general liability and workers' compensation insurance coverage. These programs provide insurance coverage for healthcare institutions associated with the Health System. The Health System also operates insurance captives, Providence Assurance, Inc. and American Unity Group, Ltd., to self-insure or reinsure certain layers of professional and general liability risk.

The Health System accrues estimated self-insured professional and general liability and workers' compensation insurance claims based on management's estimate of the ultimate costs for both reported claims and actuarially determined estimates of claims incurred but not reported. Insurance coverage in excess of the per occurrence self-insured retention has been secured with insurers or reinsurers for specified amounts for professional, general, and workers' compensation liabilities. Decisions relating to the limit and scope of the self-insured layer and the amounts of excess insurance purchased are reviewed each year, subject to management's analysis of actuarial loss projections and the price and availability of acceptable commercial insurance.

At December 31, 2016 and 2015, the estimated liability for future costs of professional and general liability claims was $302 and $216, respectively. At December 31, 2016 and 2015, the estimated workers' compensation obligation was $306 and $163, respectively, both are recorded in other current liabilities and other liabilities in the accompanying combined balance sheets.

(Continued)

(In millions of dollars)

(m) Net Assets

Unrestricted net assets are those that are not subject to donor-imposed stipulations. Amounts related to the Health System's noncontrolling interests in certain joint ventures are included in unrestricted net assets. Temporarily restricted net assets are those whose use by the Health System has been limited by donors to a specific time period and/or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Health System in perpetuity. Unless specifically stated by donors, gains and losses on permanently restricted net assets are recorded as temporarily restricted.

Temporarily restricted net assets are available for the following purposes at December 31, 2016 and 2015:

		2016	2015
Program support	$	570	184
Capital acquisition		144	60
Low-income housing and other		102	81
Total temporarily restricted net assets	$	816	325

(n) Donor-Restricted Gifts

Unconditional promises to give cash and other assets to the Health System are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the promise to give is no longer conditional. The gifts are reported as either temporarily or permanently restricted contributions if they are received with donor stipulations that limit the use of the donated assets. When the terms of a donor restriction are met, temporarily restricted net assets are reclassified as unrestricted net assets and reported as other operating revenues in the combined statements of operations or as net assets released from restriction for donations of capital in the combined statements of changes in net assets.

(o) Net Patient Service Revenues

The Health System has agreements with governmental and other third-party payors that provide for payments to the Health System at amounts different from established charges. Payment arrangements for major third-party payors may be based on prospectively determined rates, reimbursed cost, discounted charges, per diem payments, or other methods.

Net patient service revenues are reported at the estimated net realizable amounts due from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with governmental payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as appropriate. Adjustments from finalization of prior years' cost reports and other third-party settlement estimates resulted in a decrease in net patient service revenues of $1 for the year ended December 31, 2016 and an increase in net patient service revenues of $45 for the years ended December 31, 2015, respectively.

(In millions of dollars)

The composition of payors for the years ended December 31, 2016 and 2015, as a percentage of net patient service revenues, is as follows:

	2016	2015
Commercial	49%	48%
Medicare	32	32
Medicaid	16	17
Self-pay and other	3	3
	100%	100%

Various states in which the Health System operates have instituted a provider tax on certain patient service revenues at qualifying hospitals to increase funding from other sources and obtain additional Federal funds to support increased payments to providers for Medicaid services. The taxes are included in purchased services, professional fees, and other expenses in the accompanying combined statements of operations and were $495 and $528 for the years ended December 31, 2016 and 2015, respectively. These programs resulted in enhanced payments from these states in the way of lump-sum payments and per claim increases. These enhanced payments are included in net patient service revenues in the accompanying combined statements of operations and were $616 and $612 for the years ended December 31, 2016 and 2015, respectively.

(p) Allowance for Bad Debts

The Health System provides for an allowance against patient accounts receivable for amounts that could become uncollectible. The Health System estimates 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.

(Continued)

(In millions of dollars)

The estimates made and changes affecting those estimates for the years ended December 31, 2016 and 2015 are summarized below:

		2016	2015
Changes in allowance for bad debts:			
Allowance for doubtful accounts at beginning of year	$	344	290
Write-off of uncollectible accounts, net of recoveries		(276)	(132)
Provision for bad debts		203	186
Allowance for bad debts at end of year	$	271	344

(q) Charity Care and Community Benefit

The Health System provides community benefit activities that address significant health priorities within its geographic service areas. These activities include Medicaid and Medicare shortfalls, community health services, education and research, and free and low-cost care (charity care).

Charity care is reported at cost and is determined by multiplying the charges incurred at established rates for services rendered by the Health System's cost-to-charge ratio. The cost of charity care provided by the Health System for the years ended December 31, 2016 and 2015 was $174 and $180, respectively.

(r) Premium and Capitation Revenues

Premium and capitation revenues are received on a prepaid basis and are recognized as revenue during the month for which the enrolled member is entitled to healthcare services. Premium and capitation revenues received for future months are recorded as unearned premiums.

(s) Functional Expenses

The Health System provides healthcare services to residents within its geographic service areas. Expenses related to providing these services for the years ended December 31, 2016 and 2015 are as follows:

		2016	2015
Healthcare expenses	$	13,567	10,700
Purchased healthcare expenses		1,917	1,045
General and administrative expenses		3,644	2,427
Total operating expenses	$	19,128	14,172

(Continued)

(t) Subsequent Events

Effective February 23, 2017 the Health System and Catholic Health Initiatives entered into an agreement with Laboratory Corporation of America to sell all of its ownership interest in Pathology Associates Medical Laboratories and its affiliated joint ventures.

The Health System has performed an evaluation of subsequent events through, March 22, 2017, the date the accompanying combined financial statements were issued.

(u) New Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update No. (ASU) 2014-09, *Revenue from Contracts with Customers*, to clarify the principles for recognizing revenue and to improve financial reporting by creating common revenue recognition guidance for U.S. generally accepted accounting principles and International Financial Reporting Standards. The amendments in the ASU can be applied either retrospectively to each prior reporting period presented or retrospectively with the cumulative effect of initially applying the update recognized at the date of the initial application along with additional disclosures. The Health System is currently evaluating the impact of ASU 2014-09, including the methods of implementation, which is effective for the fiscal year beginning on January 1, 2018.

In March 2015, the FASB issued ASU 2015-03, *Simplifying the Presentation of Debt Issuance Costs*. This update changes the presentation of debt issuance costs in the financial statements to present such costs in the balance sheet as a direct deduction from the recognized liability rather than as an asset. Amortization of the costs is reported as interest expense. The Health System adopted the standard effective January 1, 2016 and the prior year amount of $35 has been reclassified in accordance with ASU 2015-03.

In May 2015, the FASB issued ASU 2015-07, *Fair Value Measurement (Topic 820): Disclosures for Investments in Certain Entities That Calculate Net Asset Value per Share (or Its Equivalent)*, which eliminates the requirement to categorize investments in the fair value hierarchy if their fair value is measured at net asset value per share, or its equivalent (NAV), using the practical expedient in the FASB's fair value measurement guidance. The Health System elected to early adopt this standard effective December 31, 2015. As a result of the adoption of the standard, the Health System modified its fair value hierarchy disclosures.

In February 2016, the FASB issued ASU 2016-02, *Leases*, which requires lessees to recognize a lease liability and a right of use asset for all lease obligations with exception to short-term leases. The lease liability will represent the lessee's obligation to make lease payments arising from the lease measured on a discounted basis and the right of use asset will represent the lessee's right to use or control the use of a specified asset for a lease term. The lease guidance also simplifies accounting for sale-leaseback transactions. Because of the number of leases the Health System utilizes to support its operations, the adoption of ASU 2016-02 is expected to have a significant impact on the Health System's combined financial position and results of operations. The Health System is currently evaluating the extent of the anticipated impact of the adoption of ASU 2016-02, which is effective for the fiscal year beginning on January 1, 2019 with retrospective application to the earliest presented period.

(Continued)

In August 2016, the FASB issued ASU 2016-14, *Presentation of Financial Statements of Not-for-Profit Entities,* with the intent of reducing diversity in reporting practice, reduce complexity, and enhance understandability of not-for-profit (NFP) financial statements. This ASU contains the following key aspects; (A) Reduces the number of net asset classes presented from three to two: *with donor restrictions* and *without donor restrictions*; (B) Requires all NFPs to present expenses by their functional and their natural classifications in one location in the financial statements; (C) Requires NFPs to provide quantitative and qualitative information about management of liquid resources and availability of financial assets to meet cash needs within one year of the balance sheet date; and (D) Retains the options to present operating cash flows in the statement of cash flows using either the direct or indirect method. The Health System is currently evaluating the impact of ASU 2016-14, including the methods of implementation, which is effective for the fiscal year beginning January 1, 2018.

(v) Reclassifications

Certain reclassifications have been made to prior year amounts to conform to the current year presentation.

(2) Affiliations

On July 1, 2016, PHS and SJHS entered into a business combination agreement, the purpose of which was to better serve both organizations' communities, maintain strong traditions of Catholic healthcare, and provide greater affordability and access to healthcare services. As part of the business combination, PHS and SJHS aligned under a single parent corporation, Providence St. Joseph Health, with a consolidated board of directors and cosponsorship from the public juridic persons Providence Ministries and St. Joseph Health Ministry.

SJHS provides a full range of care facilities including 16 acute care hospitals, home health agencies, hospice care, outpatient services, skilled nursing facilities, community clinics, and physician groups spanning California, west Texas, and eastern New Mexico. The results of operations of these entities have been included in the combined statements of operations of the Health System since July 1, 2016, the effective date of the business combination.

The transition was accounted for as an acquisition under Accounting Standards Codification (ASC) 958-805, *Not-for-Profit Entities – Business Combinations*. The affiliation did not involve consideration and resulted in an excess of assets acquired over liabilities assumed, reported as a contribution of net assets from SJHS to the Health System of approximately $5,644. The unrestricted portion of the contribution of $5,163 is included in net nonoperating gains in the accompanying combined statement of operations for the year ended December 31, 2016. The remaining $481 of the contribution was restricted and is recorded in restricted net assets in the combined statement of changes in net assets for the year ended December 31, 2016.

(In millions of dollars)

The following table summarizes the fair value estimate of the SJHS assets acquired and liabilities assumed as of July 1, 2016:

Cash and cash equivalents	$	359
Accounts receivable, net		607
Supplies inventory		66
Other current assets		290
Assets whose use is limited		3,372
Property, plant, and equipment, net		4,388
Other assets		555
Accounts payable		(146)
Accrued compensation		(344)
Other current liabilities		(569)
Long-term debt		(2,486)
Other liabilities		(448)
Total contribution of net assets	$	5,644

The following are the financial results of SJHS included in the Health System's 2016 combined statement of operations during the six-month period from the date of the affiliation through December 31, 2016:

Total operating revenues	$	3,520
Excess of revenue over expenses from operations		46
Excess of revenues over expenses		130

(Continued)

(In millions of dollars)

The following unaudited pro forma combined financial information presents the Health System's results as if the affiliation had been reported as of the beginning of the Health System's fiscal year of January 1, 2015:

	2016			2015		
	Actual	Pro forma (unaudited)		Actual	Pro forma (unaudited)	
Total operating revenues	$ 18,879	22,157	(1)	14,434	20,741	
(Deficit) excess of revenues over expenses from operations	(249)	(265)	(1)(2)	262	260	(2)
Excess of revenues over expenses	5,231	57	(1)	77	5,175	(3)

(1) Includes the historical results of SJHS for the six-month period ended June 30, 2016 prior to the affiliation, including the impact of purchase accounting adjustments.
(2) Includes additional depreciation related to the fair value adjustments and useful life adjustments recorded related to the affiliation.
(3) Includes the net contribution from the affiliation, in accordance with applicable accounting guidance.

Effective April 1, 2016, the Health System entered into a business combination agreement with the Institute for Systems Biology (ISB). The transaction was accounted for as an acquisition under ASC 958-805. The affiliation resulted in an excess of assets acquired over liabilities assumed, reported as a contribution from ISB to the Health System of approximately $19. The unrestricted portion of the contribution of $4 is included in net nonoperating gains in the accompanying combined statement of operations for the year ended December 31, 2016. The remaining $15 of the contribution was restricted and is recorded in restricted net assets in the combined statement of changes in net assets for year ended December 31, 2016.

(3) Fair Value Measurements

ASC Topic 820 (Topic 820), *Fair Value Measurements*, requires a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 inputs include quoted prices (unadjusted) in active markets for identical assets or liabilities that the Health System has the ability to access at the measurement date.
- Level 2 inputs include inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly.
- Level 3 inputs are unobservable inputs for the asset or liability.

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

(Continued)

(In millions of dollars)

(a) Assets Whose Use Is Limited

The fair value of assets whose use is limited, other than those investments measured using NAV as a practical expedient for fair value, is estimated using quoted market prices or other observable inputs when quoted market prices are unavailable.

The composition of assets whose use is limited at December 31, 2016 is set forth in the following table:

	December 31, 2016	Fair value measurements at reporting date using Level 1	Level 2	Level 3
Management-designated cash and investments:				
Cash and cash equivalents	$ 572	572	—	—
Equity securities:				
Domestic	1,000	1,000	—	—
Foreign	280	280	—	—
Mutual funds	828	828	—	—
Domestic debt securities:				
State and federal government	1,518	1,011	507	—
Corporate	766	—	766	—
Other	503	—	503	—
Foreign debt securities	172	—	172	—
Commingled funds	575	575	—	—
Other	32	20	12	—
Investments measured using NAV	2,752			
Total management-designated cash and investments	8,998			
Gift annuities, trusts, and other	131	32	11	88
Funds held by trustee:				
Cash and cash equivalents	147	147	—	—
Domestic debt securities	198	68	130	—
Foreign debt securities	23	—	23	—
Total funds held by trustee	368			
Total assets whose use is limited	$ 9,497			

(Continued)

(In millions of dollars)

The composition of assets whose use is limited at December 31, 2015 is set forth in the following table:

	December 31, 2015	Fair value measurements at reporting date using Level 1	Level 2	Level 3
Management-designated cash and investments:				
Cash and cash equivalents	$ 615	615	—	—
Equity securities:				
Domestic	526	526	—	—
Foreign	68	68	—	—
Mutual funds	488	488	—	—
Domestic debt securities:				
State and federal government	1,029	717	312	—
Corporate	644	—	644	—
Other	255	—	255	—
Foreign debt securities	105	—	105	—
Commingled funds	216	216	—	—
Other	1	1	—	—
Investments measured using NAV	1,186			
Total management-designated cash and investments	5,133			
Gift annuities, trusts, and other	94	24	8	62
Funds held by trustee:				
Cash and cash equivalents	177	177	—	—
Domestic debt securities	134	64	70	—
Foreign debt securities	16	—	16	—
Total funds held by trustee	327			
Total assets whose use is limited	$ 5,554			

The Health System participates in various funds that are not actively marketed on an open exchange. These investments consist of shares or units in investment funds as opposed to direct interests in the funds' underlying holdings, which may be marketable. Due to the nature of these funds the NAV per share, or its equivalent, reported by each fund manager is used as a practical expedient to estimate the fair value of the Health System's interest therein. Management believes that the carrying amounts of these financial instruments, provided by the fund managers, are reasonable estimates of fair value.

(Continued)

(In millions of dollars)

The following table presents information, including unfunded commitments as of December 31, 2016, for investments where the NAV was used to estimate the value of the investments as of December 31:

	Fair value		Unfunded commitments	Redemption frequency	Redemption notice period
	2016	2015			
Hedge funds:					
Equity hedge	$ 537	175	—	Monthly, quarterly, or annually	30–120 days
Multistrategy	364	331	—	Monthly or quarterly	5–90 days
Market dependent	184	99	—	Monthly or quarterly	2–60 days
Fund of funds	141	—	—	Quarterly or annually	90 days
Event driven	114	—	—	Monthly, quarterly, or annually	45–150 days
Commingled funds	1,022	572	—	Monthly, quarterly, or annually	6–90 days
Private equity	210	9	135	Not applicable	Not applicable
Private real estate and real assets	180	—	54	Not applicable	Not applicable
Total	$ 2,752	1,186	189		

The following is a summary of the nature of these investments and their associated risks:

Hedge funds are portfolios of investments that use advanced investment strategies such as leveraged, long, short, and derivative positions in both domestic and international markets with the goal of diversifying portfolio risk and generating return. The Health System's investments in hedge funds include certain funds with provisions that limit the Health System's ability to access assets invested. These provisions include lockup terms that range up to three years from the subscription date or are continuous and determined as a percent of total assets invested. The Health System is in various stages of the lockup periods dependent on hedge fund and period of initial investments.

Commingled funds are funds that pursue diversification of domestic and foreign equity and fixed-income securities. The Health System's investments in commingled funds have no lockup provisions or other restrictions, other than those outlined in the table above, that limit its ability to access cash.

Private equity, private real estate, and real asset funds are funds that make opportunistic investments that are primarily private in nature. These investments cannot be redeemed by the Health System; rather the Health System has committed an amount to invest in the private funds over the respective commitment periods. After the commitment period has ended, the nature of the investments in this category is that the distributions are received through the liquidation of the underlying assets.

(b) Derivative Instruments

The fair value of the interest rate swaps is based on independent valuations obtained and are determined by calculating the value of the discounted cash flows of the differences between the fixed interest rate of the interest rate swaps and the counterparty's forward London Interbank Offered Rate curve, which is the input used in the valuation, taking also into account any nonperformance risk. Collateral posted for the interest rate swaps consist of cash and U.S. government securities, which are both categorized as Level 1 financial instruments.

(In millions of dollars)

The following table presents the fair value of swaps and related collateral as of December 31, 2016:

	December 31, 2016	Fair value measurements at reporting date using Level 1	Level 2	Level 3
Cash collateral held by swap counterparty	$ 5	5	—	—
Liabilities under interest rate swaps	104	—	104	—

(c) Debt

The fair value of long-term debt is based on Level 2 inputs, such as the discounted value of the future cash flows using current rates for debt with the same remaining maturities, considering the existing call premium and protection. The carrying value and fair value of long-term debt was $6,749 and $6,980, respectively, as of December 31, 2016, and $4,079 and $4,368, respectively, as of December 31, 2015.

(d) Assets Measured Using Significant Unobservable Inputs

The following table presents the Health System's activity for assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) as defined in Topic 820 for the years ended December 31, 2016 and 2015:

Balance at December 31, 2014	$	27
Total realized and unrealized gains (losses), net		—
Total purchases		30
Total sales		(2)
Transfers into Level 3		11
Transfers out of Level 3		(4)
Balance at December 31, 2015		62
Level 3 assets acquired through affiliation		8
Total realized and unrealized gains (losses), net		1
Total purchases		16
Total sales		(3)
Transfers into Level 3		4
Transfers out of Level 3		—
Balance at December 31, 2016	$	88

(Continued)

There were no significant transfers between assets classified as Level 1 and Level 2 during the years ended December 31, 2016 and 2015.

Level 3 assets include charitable remainder trusts, real property, and equity investments in healthcare technology start-ups through the Health System's innovation venture capital fund. Fair values of real property were estimated using a market approach. Fair values of charitable remainder trusts were estimated using an income approach. Fair value of equity investments in healthcare technology start-ups were estimated using a combination of income and market approach.

(4) Debt

(a) Short-Term and Long-Term Debt

The Health System has borrowed master trust debt issued through the following:

- California Health Facilities Financing Authority (CHFFA)
- Alaska Industrial Development and Export Authority (AIDEA)
- Washington Health Care Facilities Authority (WHCFA)
- Montana Facility Finance Authority (MFFA)
- Lubbock Health Facilities Development Corp (LHFDC)
- Oregon Facilities Authority (OFA)

(Continued)

(In millions of dollars)

Short-term and long-term unpaid principal at December 31, 2016 and 2015 consists of the following:

	Maturing through	Coupon rates	Unpaid principal 2016	Unpaid principal 2015
Master trust debt:				
Fixed rate:				
Series 1997, Direct Obligation Notes	2017	7.70%	$ 1	2
Series 2005, Direct Obligation Notes	2030	4.31 – 5.39%	42	45
Series 2006A, WHCFA Revenue Bonds	2036	4.50 – 5.00%	—	211
Series 2006B, MFFA Revenue Bonds	2026	4.00 – 5.00%	—	54
Series 2006C, WHCFA Revenue Bonds	2033	5.25%	69	69
Series 2006D, WHCFA Revenue Bonds	2033	5.25%	69	69
Series 2006E, WHCFA Revenue Bonds	2033	5.25%	26	26
Series 2006H, AIDEA Revenue Bonds	2036	5.00%	—	52
Series 2008B, LHFDC Revenue Bonds	2023	4.00 – 5.00%	46	—
Series 2008C, CHFFA Revenue Bonds	2038	3.00 – 6.50%	12	16
Series 2009A, Direct Obligation Notes	2019	5.05 – 6.25%	100	165
Series 2009A, CHFFA Revenue Bonds	2039	5.50 – 5.75%	185	—
Series 2009B, CHFFA Revenue Bonds	2039	5.50%	150	150
Series 2009B, CHFFA Revenue Bonds	2021	3.00 – 5.25%	42	—
Series 2009C, CHFFA Revenue Bonds	2034	5.00%	91	—
Series 2009D, CHFFA Revenue Bonds	2034	1.70%	40	—
Series 2010A, WHCFA Revenue Bonds	2039	4.88 – 5.25%	174	174
Series 2011A, AIDEA Revenue Bonds	2041	5.00 – 5.50%	123	123
Series 2011B, WHCFA Revenue Bonds	2021	2.00 – 5.00%	51	59
Series 2011C, OFA Revenue Bonds	2026	3.50 – 5.00%	17	18
Series 2012A, WHCFA Revenue Bonds	2042	2.00 – 5.00%	489	498
Series 2012B, WHCFA Revenue Bonds	2042	4.00 – 5.00%	100	100
Series 2013A, OFA Revenue Bonds	2024	2.00 – 5.00%	61	67
Series 2013A, CFHHA Revenue Bonds	2037	4.00 – 5.00%	325	—
Series 2013B, CFHHA Revenue Bonds	2043	4.15 – 4.26%	110	—
Series 2013C, CFHHA Revenue Bonds	2043	4.15 – 4.26%	110	—
Series 2013D, Direct Obligation Notes	2023	4.38%	252	252
Series 2013D, CFHHA Revenue Bonds	2043	4.15 – 4.26%	110	—
Series 2014A, CHFFA Revenue Bonds	2038	2.00 – 5.00%	273	274
Series 2014B, CHFFA Revenue Bonds	2044	4.25 – 5.00%	119	119
Series 2014C, WHCFA Revenue Bonds	2044	4.00 – 5.00%	92	92
Series 2014D, WHCFA Revenue Bonds	2041	5.00%	179	179
Series 2015A, WHCFA Revenue Bonds	2045	4.00%	78	78
Series 2015C, OFA Revenue Bonds	2045	4.00 – 5.00%	71	71
Series 2016A, CHFFA Revenue Bonds	2047	2.50 – 5.00%	448	—
Series 2016B, CHFFA Revenue Bonds	2036	1.25 – 4.00%	286	—
Series 2016H, Direct Obligation Bonds	2036	2.75%	300	—
Series 2016I, Direct Obligation Bonds	2047	3.74%	400	—
Total fixed rate			5,041	2,963

(Continued)

(In millions of dollars)

	Maturing through	Effective interest rate (1) 2016	Effective interest rate (1) 2015	Unpaid principal 2016	Unpaid principal 2015
Variable rate:					
Series 2012C, WHCFA Revenue Bonds	2042	0.43%	0.05%	$ 80	80
Series 2012D, WHCFA Revenue Bonds	2042	0.43	0.05	80	80
Series 2012E, Direct Obligation Notes	2042	0.57	0.17	231	234
Series 2013C, OFA Revenue Bonds	2022	1.41	1.08	117	135
Series 2013E, Direct Obligation Notes	2017	4.79	3.00	100	200
Series 2016C, LHFDC Revenue Bonds	2030	0.24	—	39	—
Series 2016D, WHCFA Revenue Bonds	2036	1.04	—	106	—
Series 2016E, WHCFA Revenue Bonds	2036	0.96	—	106	—
Series 2016F, MFFA Revenue Bonds	2026	0.93	—	50	—
Series 2016G, Direct Obligation Notes	2047	0.76	—	100	—
Total variable rate				1,009	729
Commercial Paper, Series 2015B	2016	0.42	0.21	—	125
U.S. Bank Credit Facility	2016	0.92	0.56	—	13
Wells Fargo Credit Facility	2021	1.22	—	252	—
Unpaid principal, master trust debt				6,302	3,830
Premiums, discounts, and unamortized financing costs, net				167	83
Master trust debt, including premiums and discounts, net				6,469	3,913
Other long-term debt				280	166
Total debt				$ 6,749	4,079

(1) Variable rate debt, commercial paper, and credit facilites carry floating interest rates attached to indexes, which are subject to change based on market conditions.

In September and November 2016, the Health System issued $1,835 Series 2016A through 2016I revenue bonds and direct obligation notes. The intended uses of funds included refinancing legacy SJHS and PHS master trust debt and repayment of outstanding lines of credit and commercial paper. Certain issues within the 2016 series debt included remarketing provisions for which the Health System purchased supporting credit facilities that allow the Health System to treat the obligations as noncurrent though remarketing may occur within less than one year.

In August and September 2015, the Health System issued $149 of Series 2015A and 2015C fixed rate revenue bonds. The intended use of funds was to cover certain capital investment.

In connection with the Series 2016A-I issuances and the Series 2015A-C issuances, the Health System recorded losses due to extinguishment of debt of $60 and $0 in the year ended December 31, 2016 and 2015, respectively, which were recorded in net nonoperating gains (losses) in the accompanying combined statements of operations.

(Continued)

(In millions of dollars)

The following table reflects classification of long-term debt obligations in the accompanying combined balance sheets as of December 31:

		2016	2015
Current portion of long-term debt	$	200	245
Short-term master trust debt		153	138
Long-term debt, classified as a long-term liability		6,396	3,696
Total debt	$	6,749	4,079

Short-term master trust debt represents debt issues with remarketing provisions unsupported by credit facilities with mandatory redemption within one year of the December 31, 2016 and 2015.

(b) Other Long-Term Debt

Other long-term debt primarily includes capital leases, notes payable, and bonds that are not under the master trust indenture. Other long-term debt at December 31, 2016 and 2015 consists of the following:

		2016	2015
Capital leases	$	107	104
Notes payable		154	47
Bonds not under master trust indenture and other		19	15
Total other long-term debt	$	280	166

(c) Debt Service

Scheduled principal payments of long-term debt, considering all obligations under the master trust indenture as due according to their long-term amortization schedule, for the next five years and thereafter are as follows:

		Master trust	Other	Total
2017	$	182	18	200
2018		88	11	99
2019		192	8	200
2020		98	8	106
2021		355	9	364
Thereafter		5,387	226	5,613
Scheduled principal payments of long-term debt	$	6,302	280	6,582

(Continued)

(In millions of dollars)

(5) Retirement Plans

(a) Defined Benefit Plans

The Health System sponsors various frozen defined benefit retirement plans. The measurement dates for the defined benefit plans are December 31, 2016 and 2015. A rollforward of the change in projected benefit obligation and change in the fair value of plan assets for the defined benefit plans is as follows:

		2016	2015
Change in projected benefit obligation:			
Projected benefit obligation at beginning of year	$	2,600	2,827
Service cost		22	25
Interest cost		94	114
Actuarial loss (gain)		140	(135)
Benefits paid and other		(176)	(231)
Projected benefit obligation at end of year		2,680	2,600
Change in fair value of plan assets:			
Fair value of plan assets at beginning of year		1,535	1,782
Actual return on plan assets		119	(106)
Employer contributions		81	90
Benefits paid and other		(176)	(231)
Fair value of plan assets at end of year		1,559	1,535
Funded status		(1,121)	(1,065)
Unrecognized net actuarial loss		552	470
Unrecognized prior service cost		4	5
Net amount recognized	$	(565)	(590)
Amounts recognized in the combined balance sheets consist of:			
Current liabilities	$	(1)	(1)
Noncurrent liabilities		(1,120)	(1,064)
Unrestricted net assets		556	475
Net amount recognized	$	(565)	(590)
Weighted average assumptions:			
Discount rate		4.40%	4.58%
Rate of increase in compensation levels		3.50	3.50
Long-term rate of return on assets		6.90	6.80

(Continued)

(In millions of dollars)

Net periodic pension cost for the defined benefit plans for 2016 and 2015 includes the following components:

	2016	2015
Components of net periodic pension cost:		
Service cost	$ 22	25
Interest cost	94	114
Expected return on plan assets	(107)	(116)
Amortization of prior service cost	1	1
Recognized net actuarial loss	19	26
Net periodic pension cost	$ 29	50
Special recognition – settlement expense	$ 28	33

Certain plans sponsored by the Health System allow participants to receive their benefit through a lump-sum distribution upon election. When lump-sum distributions exceed the combined total of service cost and interest cost during a reporting period settlement expense is recognized. Settlement expense represents the proportional recognition of unrecognized actuarial loss and prior service cost. Settlement expense for the years ended December 31, 2016 and 2015 is included in net nonoperating gains (losses) in the accompanying combined statements of operations.

The accumulated benefit obligation was $2,628 and $2,556 at December 31, 2016 and 2015, respectively.

The following pension benefit payments reflect expected future service. Payments expected to be paid over the next 10 years are as follows:

2017	$ 183
2018	191
2019	195
2020	199
2021–2026	1,106
	$ 1,874

The Health System expects to contribute approximately $96 to the defined benefit plans in 2017.

The expected long-term rate of return on plan assets is the expected average rate of return on the funds invested currently and on funds to be invested in the future in order to provide for the benefits included in the projected benefit obligation. The Health System used 6.9% and 6.8% in calculating the 2016 and 2015 expense amounts, respectively. This assumption is based on capital market assumptions and the plan's target asset allocation.

(In millions of dollars)

The Health System continues to monitor the expected long-term rate of return. If changes in those parameters cause 6.9% to be outside of a reasonable range of expected returns, or if actual plan returns over an extended period of time, suggest that general market assumptions are not representative of expected plan results, the Health System may revise this estimate prospectively.

The target asset allocation and expected long-term rate of return on assets (ELTRA) for the years ended December 31, 2016 and 2015, respectively, were as follows:

	2016 Target	2016 ELTRA	2015 Target	2015 ELTRA
Cash and cash equivalents	1%	1%–3%	2%	1%–3%
Equity securities	42	5%–9%	47	5%–8%
Debt securities	35	2%–5%	35	2%–6%
Other securities	22	5%–9%	16	5%–8%
Total	100%	6.90%	100%	6.80%

The following table presents the Health System's defined benefit plan assets measured at fair value at December 31, 2016:

	December 31 2016	Fair value measurements at reporting date using Level 1	Level 2	Level 3
Assets:				
Cash and cash equivalents	$ 58	58	—	—
Equity securities:				
Domestic	192	192	—	—
Foreign	37	37	—	—
Mutual funds	104	104	—	—
Domestic debt securities:				
State and government	251	173	78	—
Corporate	115	—	115	—
Other	15	—	15	—
Foreign debt securities	30	—	30	—
Commingled funds	157	157	—	—
Investments measured using NAV	663			
Transactions pending settlement, net	(63)			
Total	$ 1,559			

(Continued)

(In millions of dollars)

The following table presents the Health System's defined benefit plan assets measured at fair value at December 31, 2015:

	December 31, 2015	Fair value measurements at reporting date using Level 1	Level 2	Level 3
Assets:				
Cash and cash equivalents	$ 64	64	—	—
Equity securities:				
Domestic	262	262	—	—
Foreign	37	37	—	—
Mutual funds	31	31	—	—
Domestic debt securities:				
State and government	242	169	73	—
Corporate	116	—	116	—
Other	8	—	8	—
Foreign debt securities	15	—	15	—
Commingled funds	154	—	154	—
Other	8	—	8	—
Investments measured using NAV	623			
Transactions pending settlement, net	(25)			
Total	$ 1,535			

The Health System's defined benefit plans participate in various funds that are not actively marketed on an open exchange. These investments consist of shares or units in investment funds as opposed to direct interests in the funds' underlying holdings, which may be marketable. Due to the nature of these funds the NAV per share, or its equivalent, reported by each fund manager is used as a practical expedient to estimate the fair value of the Health System's interest therein. Management believes that the carrying amounts of these financial instruments provided by the fund managers are reasonable estimates of fair value.

The following table presents information for investments where either the NAV per share or its equivalent was used to value the investments as of December 31:

	Fair value 2016	Fair value 2015	Redemption frequency	Redemption notice period
Hedge funds:				
Multistrategy	$ 162	173	Monthly or quarterly	5 – 90 days
Equity hedge	74	93	Monthly or quarterly	30 – 65 days
Fund of funds	1	4	Monthly	30 days
Commingled funds	426	353	Monthly	6 – 30 days
Total	$ 663	623		

(Continued)

(In millions of dollars)

(b) Defined Contribution Plans

The Health System sponsors various defined contribution retirement plans that cover substantially all employees. The plans provide for employer matching contributions in an amount equal to a percentage of employee pretax contributions, up to a maximum amount. In addition, the Health System makes contributions to eligible employees based on years of service. Retirement expense related to these plans was $440 and $323 in 2016 and 2015, respectively, and is reflected in salaries and benefit expense in the accompanying combined statements of operations.

(6) Commitments and Contingencies

(a) Commitments

Firm purchase commitments, primarily related to construction and equipment and software acquisition, at December 31, 2016 are approximately $249.

(b) Operating Leases

Leases

The Health System leases various medical and office equipment and buildings under operating leases. Future minimum lease commitments under noncancelable operating leases for the next five years and thereafter are as follows:

2017	$	216
2018		205
2019		187
2020		168
2021		148
Thereafter		896
	$	1,820

Rental expense, including month-to-month leases and contingent rents, was $302 and $217 for the years ended December 31, 2016 and 2015, respectively, and is included in other expenses ins the accompanying combined statements of operations.

(c) Litigation

The healthcare industry is subject to numerous laws and regulations from federal, state, and local governments. Compliance with these laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time. Government monitoring and enforcement activity continues with respect to investigations and allegations concerning possible violations by healthcare providers of regulations, which could result in the imposition of significant fines and penalties, as well as significant repayments of patient services previously billed. Institutions within the Health System are subject to similar regulatory reviews.

Management is aware of certain asserted and unasserted legal claims and regulatory matters arising in the course of business. After consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on the Health System's combined financial statements.

The care and services Providence delivers spans from birth to hospice, to care for the whole person. Our comprehensive scope of services includes acute care, physician clinics, long term and assisted living, palliative and hospice care, home health, education and supportive housing. Our ministries are in Alaska, California, Montana, Oregon and Washington with our system office located in Renton, Washington.

PROVIDENCE
Health & Services

Introduction to Management's Discussion and Analysis

Management's discussion and analysis provides additional narrative explanation of the financial condition, operational results and cash flow of Providence Health & Services (Providence) to increase understanding of the health system's combined financial statements. The discussion and analysis should be read in conjunction with the accompanying audited combined financial statements.

Creating healthier communities, together

As health care evolves, Providence is responding with a vision and core strategy to transform and innovate at scale. Across five states, Providence and its affiliates continue to pioneer how care is delivered by sharing one strategic plan designed to improve the health of entire populations by supporting the well-being of each person we serve. Our core strategy of "*Creating healthier communities, together*" is supported by five specific areas of focus in our strategic plan:

- Inspire: We must first inspire and develop our people.
- Know: To serve our communities effectively, we are building enduring relationships with consumers.
- Partner: Providing the best care requires new alignments with clinicians and care teams.
- Adapt: We'll develop and thrive under new care delivery and economic models.
- Adopt: To serve more people we will grow by optimizing expert-to-expert capabilities.

This plan supports our vision, "Together, we answer the call of every person we serve: Know me, care for me, ease my way ®," which is our promise to our patients, customers and communities. Through innovation, excellence, good stewardship and working together across Providence, we will continue to lead change to improve the health of our communities.

Investing in our communities to improve health and increase access

With strong support from Providence, Alaska launched Medicaid expansion in 2015 and Montana began expansion early in 2016, ensuring that all five of our states have increased eligibility under the Affordable Care Act. In an environment of decreased reimbursement for government-sponsored medical care, community benefit spending related to the unpaid costs of Medicaid was $538 million in 2015 compared with $444 million in 2014. Providence cares for everyone, regardless of their ability to pay. In 2015 we provided more than $951 million in community benefit, which increased over $100 million from 2014.

Providence had a strong impact on landmark new payment codes that recognize the value of advance care planning by reimbursing clinicians for having these discussions with their patients. The Centers for Medicare and Medicaid Services adopted recommendations developed by Providence and our partners that advance care planning be added as an optional, separately billable, element of the annual wellness visit. Going into effect in 2016, these codes will be instrumental for Providence, other Catholic ministries, and other providers that are committed to whole-person care models.

Together, we answer the call of every person we serve: Know me, care for me, ease my way.

Collaborating with like-minded partners

St. Joseph Health System

Providence and St. Joseph Health continue to work through the process of bringing our organizations together after signing a letter of intent in July 2015 and a definitive agreement in November 2015 to create a new single organization. Closure of the transaction is dependent on the timing of regulatory review, which we now estimate will be complete in the second quarter of 2016.

The two Catholic health systems, with long histories of serving communities in the American West, plan to create a new parent organization, Providence St. Joseph Health, that will focus on a shared mission and vision, as well as the strategic, financial and operational direction for the system overall. Dr. Rod Hochman will serve as the CEO of the parent organization, which will be based in Renton, Wash. There will be two system offices - in Renton and in Irvine, Calif. The board of directors of the parent organization will include seven members appointed by Providence and seven members appointed by St. Joseph Health.

> *"Together, we can invest more in the needs of everyone we serve, especially the most vulnerable,"*
> ***-Rod Hochman, M.D., President and CEO***

Walgreens

As part of our commitment to creating healthier communities together, Providence is collaborating with Walgreens to open 25 clinics in Walgreens stores in Oregon and Washington during the next two years, starting with six clinics in Portland and Seattle opening in February 2016. In Portland, the clinics will be operated by Providence, staffed by Providence providers, and called Providence Express Care at Walgreens and in the Seattle area will be operated by Swedish, staffed by Swedish providers, and called Swedish Express Care at Walgreens. This program is another way we are answering the call of every person we serve. Current patients will experience a seamless patient experience through our existing electronic health record system, providing direct connectivity to the clinics and billing systems which will ensure better continuity of patient care and collaboration among providers.

Greater Fairbanks Community Hospital Foundation

Providence has signed a letter of intent with the Greater Fairbanks Community Hospital Foundation to pursue a lease agreement under the secular entity Western HealthConnect. The agreement would cover operations for Fairbanks Memorial Hospital, Denali Center and Tanana Valley Clinic. Fairbanks Memorial Hospital has 152 licensed beds and has served the community for more than 40 years.

The Hospital Foundation began a search for a new lease agreement partner after deciding not to renew a 15-year affiliation with Arizona-based Banner Health. Providence is honored to be selected as their proposed new partner and look forward to working with the Hospital Foundation to create healthier communities, together. We are excited to continue this tradition and to return to the Fairbanks community, where we served from 1910 to 1968.

As part of the letter of intent, we will negotiate a transition lease - under essentially the same terms as Banner - with the intent to negotiate a multi-year lease in the future. The lease agreement will be with Western HealthConnect, the entity formed to allow Providence to remain Catholic and secular affiliates to

remain secular. This is the same model we used for our affiliations with Swedish, Pacific Medical Centers and Kadlec.

Leading dynamic change through innovation

Population Health

Population health will be a critical part of achieving Providence's strategy of creating healthier communities, together. Our goal is to maximize the health outcomes of the people in our defined populations and communities through the design, delivery and coordination of affordable quality health care. We are focused on the customer experience, while driving operational and financial excellence though our innovation in this space.

Consumer Health Engagement and Support

Our innovation team is developing tools and services that engage consumers to keep them healthy between episodes of care. For example, we will test a new service line for our 65 and over population that aims to increase the options seniors have in the choice to safely age in place in their homes and defer the stress and costs of a move to a long term care facility. The program will partner with our clinics to support day to day living tasks like meal delivery and transportation, improve the safety of a senior's home, and provide trusted planning and advice about aging optimally.

Leadership in the Healthcare Industry

Rod Hochman, M.D., president and chief executive officer, was recently appointed to the Board of Trustees for the Catholic Health Association of America.

Mike Butler, president, operations and services, has joined the Board of Directors of Medical Teams International.

Amy Compton-Phillips, M.D., executive vice president and chief clinical officer, along with **Rhonda Medows**, M.D., executive vice president of population health, were recently listed in Becker's Hospital Review annual list of influential female leaders in health care.

Providence ExpressCare

In order to provide health care to our patients on their own terms through a diverse range of care delivery offerings, Providence has launched ExpressCare, where patients can receive primary care in a retail setting. In addition to twenty-five ExpressCare Walgreens-embedded clinics, twenty-five standalone retail clinics will be opening throughout Washington, Oregon, California, and Montana in 2016 and 2017. ExpressCare clinics will be equipped with in-clinic "Appointments Now Available" monitors, website registration and scheduling, as well as walk-in kiosks with scheduling, check-in, and registration. ExpressCare will also be supported by a mobile app with clinic search, scheduling, registration and MyChart access as well as integrated telehealth.

Telehealth

Significant progress was made on our 2015 priorities including: iterating on and rolling out a new B2B technical infrastructure, turning on self-service features, accelerating deployment velocity and efficiency, and developing capabilities to be able to deploy easily to new service lines. We have developed a fully integrated platform that will effectively support both expert-to-expert telehealth as well as direct to consumer telehealth. Priorities for 2015 included improving quality of communication for clinicians and

patients, reduced cost and accelerated deployment, safe and easy self-service features, and developing capabilities to be able to deploy easily to new service lines. The expert-to-expert telehealth platform for Telestroke was launched in 43 locations, while the Telehospitalist program completed a successful pilot and is now being deployed more broadly. HealthExpress, our $39 urgent care telehealth offering is now available in Washington and Oregon. Visit http://healthexpress.com to learn more.

Providence Milestones

- Named as one of the 'Most Wired' organizations in health care by the American Hospital Association.
- Ranked 153 of 500 on the Forbes list of America's Best Employers in 2015.
- The power of our Mission continues to shine through in a recent survey with 92 percent of caregivers (all employees) agreeing with the statement, "My work supports the Mission."

Financial Performance

Year-end Results

Key Financial Indicators *Data is year-to-date; dollar figures presented in millions*	2015	2014	Organic Growth*
Net Operating Income	$262	$219	$233
Net Income	$77	$771	$44
EBIDA	$864	$1,133	$807
Total Community Benefit	$951	$848	$931
Operating Margin %	1.8%	1.8%	1.7%
Accounts Receivable Days	47	50	48
Days of Cash on Hand	159	183	163
Long-term Debt to Total Capitalization	33.8%	33.8%	33.3%
Cash to Debt	138.1%	130.9%	148.2%

** Reflects 2015 year-to-date results from entities that have been affiliated with Providence for more than 12 months.*

Operating income increased by 19.5 percent over the prior year, growing from $219 million in 2014 to $262 million in 2015. Operating margin remained consistent with the prior year at 1.8 percent while revenues continued to increase in 2015. Total net service revenue grew 16.7 percent or $1.7 billion over the prior year from $10.1 billion in 2014 to $11.8 billion in 2015 driven by higher volumes and the recognition of revenue from state provider tax programs.

While operating income experienced positive growth in 2015, annual investment performance had a negative impact on Providence's net income and earnings before interest, depreciation, amortization and affiliation gains (EBIDA) as a result of challenging market conditions. Total investment losses for the year were $114 million as compared to $178 million in positive investment income in 2014. As a result, net income for the twelve months ended December 31, 2015 was $77 million as compared to $771 million in the prior year. Net non-operating income, excluding investment income, was -$71 million in 2015 compared to $374 million in 2014. The 2015 non-operating income was primarily impacted by pension settlement costs, while 2014 was benefited from affiliation related gains, partially offset by extinguishment of debt and pension settlement costs. EBIDA was $864 million in 2015 as compared to $1,133 million in 2014.

Several of the states we serve operate broad-based provider tax programs to fund the non-federal share of Medicaid. Providence recorded net operating income of $84 million during the twelve months of 2015 related to these programs, compared to no related revenue in the prior year. Timing of program approval by regulating agencies can impact the timing of recognizing related income, and as a result, approximately $50 million of the provider tax income recorded in 2015 related to services provided in 2014.

Liquidity & Capital

Unrestricted cash reserves totaled $5.8 billion as of December 31, 2015 compared to $6.0 billion as of December 31, 2014. The decrease was primarily driven by investment losses, capital purchases, and debt payments made during the year, partially offset by cash generated from operations.

Days cash on hand (DCOH) decreased 24 days from 183 days on December 31, 2014 to 159 days on December 31, 2015. This decline was driven by a combination of factors. First, a reduction in cash reserves primarily driven by investment losses. Second, patient volume growth led to higher operating revenues and corresponding expenses year over year.

Volumes

Key Volume Indicators *Data is year-to-date; presented in thousands unless noted*	2015	2014	Organic Growth*
Inpatient Admissions	362	333	353
Acute Adjusted Admissions	651	602	633
Total Emergency Room Visits	1,457	1,332	1,411
Total Surgeries	244	227	238
Continuum Services Visits	2,319	2,272	2,319
Physician Care Visits	7,742	6,881	7,443
Connected Lives - Member Months	6,050	5,147	6,050
Observations	56	58	56
Rate - Net Service Revenue/CMAA (whole value)	$12,295	$11,499	$12,299
CMI Adjusted Length of Stay (whole value)	2.9	2.9	2.9

** Reflects 2015 year-to-date results from entities that have been affiliated with Providence for more than 12 months.*

Providence's continued investment in our communities and strategy of collaborating with like-minded partners led to higher acute setting volumes in 2015. Year-to-date inpatient admissions of 362 thousand were 29 thousand or 8.7 percent higher than the prior year. Year-to-date surgeries of 244 thousand were 17 thousand higher than prior year, which represented a 7.3 percent increase. Surgery counts increased in both inpatient and outpatient categories with inpatient increasing 8.7 percent and outpatient increasing 6.1 percent in 2015 as compared to 2014. Emergency visits were 125 thousand visits or 9.4 percent higher in 2015.

Strategic focus and innovations in clinical and home based care led to growth in these categories in 2015. Physician visits of 7,742 thousand were 861 thousand visits higher than the prior year, an increase of 12.5

percent. Continuum services, which include long term care, hospice, housing, assisted living and home health, generated 2,319 thousand visits year-to-date, which was 2.1 percent higher than the prior year.

The Providence Health Plan has continued to expand its services in the changing coverage landscape. Connected lives member months, a measure of coverage for insured members, increased from 5,147 member months in 2014 to 6,050 member months in 2015. This growth in member coverage represented a 17.5 percent increase compared to the prior year. Enrolled members, including Administrative Services Only (ASO) members, grew 17 percent from 437 thousand in December 2014 to 513 thousand in December 2015.

Revenue

Operating Revenue *Data is year-to-date; figures presented in millions*	2015	2014	Organic Growth*
IP Net Service Revenue	$ 6,386	5,306	6,235
OP Net Service Revenue	3,381	3,145	3,252
Primary Care	1,486	1,232	1,465
Continuum Services	715	612	715
Capitated & Premium Revenue	1,862	1,683	1,814
Bad Debt	(186)	(193)	(179)
Other Revenue	790	696	781
Total Operating Revenue	**$ 14,434**	**12,481**	**14,083**

** Reflects 2015 year-to-date results from entities that have been affiliated with Providence for more than 12 months.*

Year-to-date operating revenue of $14.4 billion was $2.0 billion or 15.6 percent greater than prior year. Revenue included $612 million from provider tax related programs, of which $240 million was related to the prior year. Payments related to 2014 were recorded in 2015 due to the timing of program approvals from state agencies that administer the provider fee programs. Capitated revenue of $399 million was 17.6 percent higher than the prior year as a result of growth in our accountable care organizations. Total premium revenue of $1,464 million was 8.9 percent higher as membership in the Providence Health Plans expanded in 2015. Premium revenue grew at a slower rate than enrollments primarily due to a change in product mix from 2014 to 2015, which saw a general shift towards more high deductible plans. Capitated and premium revenue represented 13 percent of Providence's total operating revenue, in line with the prior year.

Since 2012 Providence has participated in federal programs designed to provide incentive funding to hospitals and providers that implement electronic health record systems. Providence recorded $22 million in revenue in 2015 related to this meaningful use funding, which was lower than the $55 million recorded in 2014. This year-over-year decrease was expected as most providers and hospitals near the end of the three year incentive program.

Operating Expenses

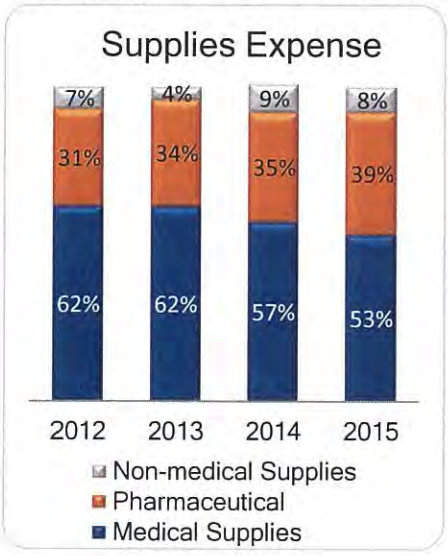
Key Efficiency Indicators *Data is year-to-date*	2015	2014	Organic Growth*
FTEs (presented in thousands)	70.4	65.4	67.1
Productivity - Labor % Net Service Rev.	50.8%	52.0%	50.9%
Supplies % Net Service Revenue	17.6%	17.7%	17.5%
Efficiency - Expense/CMAA	$ 12,040	$ 11,270	$ 12,070

** Reflects 2015 year-to-date results from entities that have been affiliated with Providence for more than 12 months.*

Year-to-date operating expenses were 15.6 percent higher than the prior year, which followed the 15.6 increase in operating revenue. Fees from provider tax related programs were $528 million in 2015 while no related expenses were recorded in 2014. Timing of program approval by regulating agencies resulted in all 2014 related expenses totaling $190 million being recorded in 2015. Expense growth was correlated with the higher patient volumes experienced in 2015. After removing the impact of provider fee taxes, growth of salary expenses and supply expenses outpaced operating expenses on a percentage basis, while benefits expenses and depreciation grew at a slower pace.

Year-to-date labor expense, defined as the combination of salaries and wages, employee benefits, and purchased services, was $1.0 billion or 13.4 percent higher than the prior year. Full-time equivalents (FTEs) of 70.4 thousand increased 7.6 percent, which represented an increase of 5.0 thousand FTEs. Labor expense growth outpaced FTEs in part due to high utilization of agency labor in 2015 to staff open positions. Agency labor increased 69 million or 42.3 percent in 2015 compared to the prior year. Higher salary expense was also a reflection of strategic investments made to move Providence to an institutes model of management. Total salary expense increased 14.0 percent while total benefits expense increased 11.3 percent compared to the prior year. Per member per month (PMPM) employee medical costs in 2015 were 3.8 percent higher over the prior year in part due to higher pharmaceutical costs.

Supply expenses increased $279 million or 15.6 percent compared to the prior year, but decreased slightly as a percentage of total net service revenue from 17.7 percent in 2014 to 17.6 percent in 2015. Medical supply expenses, a component of total supply expenses, increased 8.7 percent compared to the prior year which was in line with the growth in volume increases. Pharmaceutical expenses, the other significant component of supply expense, increased 30.4 percent compared to the prior year. Just under a third of the increase was volume driven with the remainder a result of price increases. Ten drugs accounted for 33 percent of the year-over-year price inflation from wholesaler drug purchases. Particularly high inflation was experienced among sole-source generic drugs and specialty pharmaceuticals. Market forces continue to move toward consolidation of generic drug producers, leading to significant price increases. In 2015 half of drugs purchased by Providence were branded drugs for which we have no ability to negotiate discounted rates. Continued consolidations of generic



drug producers is reducing the availability of options in the generics market by converting low cost generics to sole source branded suppliers.

Non-operating Income

Non-operating gains and losses are primarily comprised of investment income, pension settlement costs, and innovation projects expense. Pension settlement costs and innovation expenses were $34 million and $27 million through December, respectively. The remaining balance of non-operating income was driven by investment losses for the year, which were $114 million as compared to $178 million in positive investment income in 2014.

Investment Performance

Allocation by Asset Class *(Dollar figures presented in millions)*	Providence 12/31/15 Balance	Percent Allocation	Annual Return
Equities	$1,314	23%	$(54)
Fixed income	2,231	38%	2
Alternative Investments	861	15%	(66)
Cash & Other	1,396	24%	4
Total	**$5,802**	**100%**	**$(114)**

Within our portfolio, we saw growth hedge funds and our public and private debt positions outperform their respective indices for the year. Assets underperformed largely due to current allocations to Master Limited Partnerships (MLPs), Risk Parity and Commodities.

On a year-to-date basis, consolidated asset investments returned -3.22 percent, compared to the policy benchmark return of -2.54 percent. On a relative basis, our public equity pool returned -4.72 percent, driven by severe underperformance in Risk Parity, compared to the MSCI AC World IMI index return of -2.19 percent. Fixed income assets for the year returned 0.95 percent compared to the Barclays US Aggregate Index annual return of 0.55 percent; and our Alternative Investments returned 1.48 percent compared to our Alternative Investment Composite benchmark return of 1.03 percent.

Credit Agency Ratings

Providence received affirmation on the following ratings from the three national credit rating agencies during the latest round of reviews in June and July.

- Fitch: "AA"
- Standard and Poor's: "AA-"
- Moody's: "Aa3"

Ratings from all three agencies remained unchanged from the prior year, and all agencies issued a stable outlook based on improved year-over-year operating performance and stable balance sheet measures.

Debt Supported by Self-Liquidity

PH&S has authorized $200 million in taxable commercial paper that is supported by self-liquidity. As of December 31, 2015, $125 million in commercial paper was outstanding.

The System reports monthly on its cash and investment balances available to retire maturing short-term debt in the event notes cannot be remarketed. The table below summarizes the information provided to the rating agencies at the end of the fourth quarter describing cash and investments that could be available for liquidation.

Standard & Poor's Liquidity Assessment Coverage Calculation Spreadsheet (Last Revised January 2010)

INSTRUCTIONS: Fill in Green Cells to Compute Coverage Amounts

Liquidity Assessment Provider Name: Providence Health & Services
Portfolio As of Date: December 31, 2015

Asset Allocation (Security Type)	Assets ($ millions) with same day liquidity (T+0)	Assets ($ millions) with next day liquidity (T+1)	Assets ($ millions) with > same day liquidity (T+2, T+3,...T+n)	$ in Millions	Discount Factor	Discounted Assets
Cash & Cash Equivalents *	$ 524.03	$ -	$ -	$ 524.03	1.00	$ 524.03
S&P rated money market funds (> Am)	$ 206.41	$ -	$ -	$ 206.41	1.00	$ 206.41
Highly rated (A-1 or A-1+) dedicated bank line	$ -	$ -	$ -	$ -	1.00	$ -
Highly rated (A-1 or A-1+) money market instruments (< 1yr)	$ -	$ 4.01	$ -	$ 4.01	0.91	$ 3.64
U.S. Treasury Debt Obligations (> 1 year)	$ -	$ 304.34	$ -	$ 304.34	0.91	$ 276.67
U.S. TIPs	$ -	$ 94.25	$ -	$ 94.25	0.87	$ 81.95
U.S. Agencies (> 1 year)	$ -	$ 95.97	$ -	$ 95.97	0.83	$ 79.97
Investment Grade Debt (that is not included above)	$ -	$ -	$ 229.16	$ 229.16	0.67	$ 152.78
Equities**	$ -	$ -	$ 393.41	$ 393.41	0.50	$ 196.71
Non-Investment Grade Debt	$ -	$ -	$ 6.87	$ 6.87	0.40	$ 2.75
Total	$ 730.44	$ 498.56	$ 629.45	$ 1,858.44		$ 1,524.91
Discounted Total	$ 730.44	$ 442.24	$ 352.23			Discounted Total

	Enter amount of Self Liquidity Backed Debt with:		
	Same Day Notice	Next Day Notice	> Next Day Notice
Commercial Paper		$ 100.00	$ 100.00
Variable Rate Demand Note or Obligation	$ -		$ -
Fixed Rate Debt			
Other Securities			
Total	$ -	$ 100.00	$ 100.00
Remaining Discounted Assets	$ 730.44	$ 1,072.68	$ 1,324.91
	Same Day +/-	Next Day +/-	> Next Day +/-
	Sufficient	Sufficient	Sufficient

TOTAL DEBT SUPPORTED BY SELF LIQUIDITY	TOTAL REMAINING DISCOUNTED ASSETS
$ 200.00	$ 1,324.91

Performance Metrics	December 31, 2015		
	Year-To-Date Actual	Year-To-Date Budget	Year-To-Date Last Year
Volume:			
Acute Adjusted Admissions	651,198	630,518	602,468
Total Acute Admissions	361,689	352,410	333,263
Total Acute Patient Days	1,630,317	1,561,749	1,495,451
Acute Outpatient Visits	8,484,580	8,297,727	8,005,170
Observations	56,353	58,908	57,965
Primary Care Visits	7,741,961	7,789,622	6,881,113
Long-Term Care Patient Days	410,672	420,836	411,517
Home Health Visits	697,040	679,430	667,708
Hospice Days	642,506	663,325	628,182
Housing and Assisted Living Days	568,913	525,451	564,110
Health Plan Members	513,113	461,681	436,930
Total Occupancy %	64.8%	62.4%	59.5%
Total Average Daily Census	4,467	4,279	4,097
Surgeries:			
Inpatient	115,639	112,853	106,414
Outpatient	128,263	119,803	120,890
Total Surgeries	243,902	232,656	227,304
Emergency Room Visits:			
Inpatient	195,313	189,860	179,129
Outpatient	1,261,493	1,176,269	1,152,536
Total Emergency visits	1,456,806	1,366,129	1,331,665
Outpatient Visits:			
Outpatient Surgery	128,263	119,803	120,890
Emergency Visits	1,261,493	1,176,269	1,152,536
Primary Care	7,741,961	7,789,622	6,881,113
Homecare Visits	697,040	679,430	667,708
Observations	56,353	58,908	57,965
All Other	7,038,471	6,942,748	6,673,778
Total Outpatient Visits	16,923,581	16,766,780	15,553,990

Performance Metrics	December 31, 2015		
	Year-To-Date Actual	Year-To-Date Budget	Year-To-Date Last Year
Efficiency:			
FTE's	70,438	69,328	65,369
YTD Overall Case-Mix Index	1.5738	1.5635	1.5699
YTD Case-Mix Adj Admissions (CMAA)	1,024,874	985,840	945,794
YTD Acute Care LOS (case-mix adj)	2.9	2.8	2.9
YTD Net Svc Rev/CMAA	12,295	11,931	11,499
YTD Net Expense/CMAA	12,040	11,727	11,270
YTD Paid Hours/CMAA	143	146	140
YTD Productive Hours/CMAA	127	130	124
FTE's Per Adjusted Occupied Bed	8.76	9.06	8.62
Financial Performance:			
Operating Margin	1.8%	1.5%	1.8%
Total Margin	0.5%	3.5%	5.9%
EBIDA ('000)	864,158	1,341,871	1,132,694
EBIDA Margin	6.0%	9.9%	5.7%
R12 Days of Total Cash on Hand	159	156	183
Net Patient AR Days (3 mo rolling ave)	47	63	50
Ave Yearly Salary/FTE (w/o benefits)	84,950	83,353	82,171
Employee Benefits as a % of Salaries	22.7%	23.9%	23.2%
Salary Wages as a % of Net Op Rev	41.5%	42.5%	42.0%
Supplies as a % of Net Op Revenue	14.4%	13.7%	14.4%
YTD Supplies Expense/CMAA	2,022	1,886	1,895
YTD Med Supplies Exp/CMAA	1,077	1,045	1,073
Debt to Total Net Asset Ratio	33.8	30.6	33.8
Cash to Debt Ratio	138.1	131.4	130.9
Current Ratio	1.4	1.8	1.5
Bad Debt & Charity % Gross Svc Rev	2.2%	3.0%	2.8%
Community Benefit: ('000)			
Cost of Charity Care Provided	$ 180,256	$ 215,219	$ 205,555
Medicaid Charity	537,894	460,180	443,622
Education and Research Programs	112,826	79,288	96,988
Unpaid Cost of Other Govt Programs	47	1,088	1,157
Negative Margin Services and Other	68,095	61,507	57,355
Non-Billed Services	52,206	26,025	43,806
Total Community Benefit	$ 951,324	$ 843,307	$ 848,483

Providence St. Joseph Health

Management's Discussion and Analysis of Financial Condition and Results of Operations

Year ended December 31, 2017

About Providence St. Joseph Health

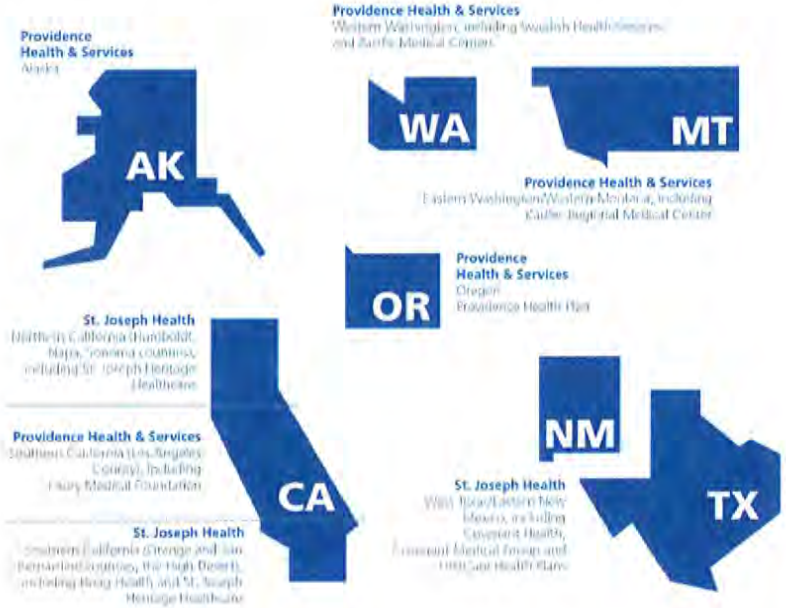
Our Organization

Providence St. Joseph Health (the System) has been a strong and stable force in health care for more than 160 years. In 2016, Providence Health & Services and St. Joseph Health came together as one national health system with the goal of improving the health of the communities we serve, especially the poor and vulnerable. During 2017, the System generated revenues of $23 billion, an increase of 5 percent over the prior year. In addition, we have invested $1.6 billion in community benefit in support of our Mission.

> *"Together, we can invest more in the needs of everyone we serve, especially the most vulnerable,"*
> ***-Rod Hochman, M.D., President and CEO***

While we have sustained our performance, we strive to increase access to health care and bring quality, compassionate care to those we serve, regardless of coverage or ability to pay. We are privileged to serve in fast growing markets in the western United States with growing populations, which has led to consistent increases in our services in these markets. We believe that health care is a basic human right and experience has shown us that when individuals and families have access to care, quality of life improves. We offer a comprehensive range of industry-leading services, including an integrated care delivery system for inpatient and outpatient services, directly employed and affiliated physicians, health plans, senior care and housing programs, financial assistance programs for those unable to pay their medical bills and educational ministries. With a shared commitment to transform health care, we are pioneering new care settings, population health, and solutions in clinical research and investing in digital technologies. Together, we are bringing quality care to all, with a focus on those most in need, and we are consistent advocates on behalf of the vulnerable and marginalized.

We employ more than 114,000 caregivers (employees) who serve in 50 hospitals, over 800 clinics and hundreds of programs and services across seven states.



Industry Trends

Providers are adapting to a rapidly changing industry and finding innovative ways to provide better, more affordable care and consumer-centric services. More hospitals and health systems are making innovative digital offerings that better engage customers, improve continuum of care and reduce clinical and operational variations and costs. With the advent of cloud computing and regulatory changes improving access for patients and sharing medical information, there will be more demand for applications that reduce friction in the system. These advancements will also improve collaboration between caregivers and patients using real-time data that improves managed and preventive care and enables more effective, customized health regimens. Advances in technology are improving the quality of care, such as direct-to-consumer tests, integrating genomic data and other personal health information with clinical labs. We anticipate the following developments ahead:

- **Technology** - Digital transformation will be increasingly important to empower patients to become more involved in their care as providers leverage cloud computing, artificial intelligence and machine learning, and consumer engagement platforms in health care
- **Personalized Medicine** - Using medicine, big data/analytics, and social networks
- **Population Health** - A stronger focus on the social determinants of health is ahead through ongoing improvements in analytics and care management to help prevent illness and care for those with chronic conditions
- **Workforce** - Sourcing a wide base of healthcare talent to meet the challenges of providing cost-effective, high-quality care will demand new and inventive workforce strategies
- **Ambulatory and Home Health** - Providers will offer convenient at-home services that utilize video, email, online chat or text to provide patients with more opportunities to manage their health and wellness
- **Partnerships** - Successful traditional and non-traditional partnerships will expand access, improve efficiencies, and help reduce or stabilize costs for medical supplies and pharmaceuticals

Policy and Advocacy

Our advocacy agenda for 2018 maintains a vigorous focus on protecting and advancing gains in health insurance coverage with a special emphasis on Medicaid and Medicare. Responding to the needs of our communities, advocacy will endorse initiatives to help pioneer new paths in health care, advance population health strategies and respond to provider shortages. The System will continue to be a voice for the vulnerable in our communities and nation promoting legislative solutions that improve quality and access to care.

Throughout 2017, our family of organizations served as strong advocates in Congress and state legislatures for the preservation of coverage gains and access to care, and the stability of health insurance markets. As a mission-driven health system, we maintain a special focus on serving those who are poor and vulnerable and advocating for safety net programs that they depend on, particularly Medicaid. Uncertainty about the scope of government-sponsored insurance and levels of reimbursement was significant in 2017, and we expect these trends to continue into 2019, as governments face budgetary restraints. At least two of the states we serve are now reducing Medicaid payments or taxing providers and insurers for budget relief. Even with passage of a bill to fund the federal Children's Health Insurance Program for 10 years, we do not expect government reimbursement to keep up with industry costs and have developed operational and financial management strategies to respond accordingly.

The tax overhaul passed in late 2017 maintains not-for-profit hospital access to tax-exempt debt, which is an important tool in helping us to manage our infrastructure costs and allowing for continued investments in

our communities. Another provision repeals the Affordable Care Act's individual mandate in 2019 that requires most Americans to have a minimum level of health insurance. As a result, the uninsured rate is expected to rise by several million, leading to poorer health and more need for free or subsidized care.

Strategy

As health care evolves, we are responding with a vision and core strategy to transform and innovate at scale. Across the western United States, we share one strategic plan designed to improve the health of entire populations by supporting the well-being of each person served. That integrated strategic and financial plan is supported by three key principles:

Strengthen the Core. We will deliver outstanding, affordable health care, housing, education and other essential services to our patients and communities by:

- Delivering safe, compassionate, high-value health care
- Stewarding our resources with a rigor and discipline that enables improved operational earnings into the future
- Fostering community commitment to our Mission via philanthropy
- Creating a work experience where caregivers are developed, fulfilled and inspired to carry on the Mission

Be Our Communities' Health Partner. We will be our communities' health partner, aiming for physical, spiritual and emotional well-being. We seek to ease the way of our neighbors by:

- Transforming care and improving population health outcomes, especially for the poor and vulnerable
- Leading the way in improving our nation's mental and emotional well-being
- Extending our commitment to whole person care for people at every age and stage of life
- Engaging with partners in addressing the social determinants of health, with a focus on education, housing and the environment
- Being the preferred health partner for those we serve

Transform Our Future. We will respond to the evolving health care landscape, pursuing new opportunities that transform our services, in a strategic and effective manner. We seek to expand our share of lives and health spend and further sustain our Mission by:

- Continuing the shift toward a consumer-centric health organization with multiple, convenient access points
- Digitally enabling, simplifying, and personalizing the health experience
- Engaging and initiating strategic partnerships along the care continuum
- Creating an integrated scientific wellness, clinical research and genomics program that is nationally recognized for breakthrough advances
- Utilizing insights and value from data to drive strategic transformation
- Activating the voice and presence of the System nationally to improve health policies

In support of our Strategic Plan, we will manage and deploy our resources to their highest and best use to sustain our Mission by:

- Allocating capital in support of our Strategic Plan
- Introducing more rigor and financial discipline in our Capital allocation process with an emphasis on our Return-on-Invested Capital (ROIC)
- Diversifying our care delivery and payment models to capture more value and align with community and industry trends
- Developing premium assets and services where we have unique advantages and/or leverage disruptive technologies

- Unlocking the value in our non-core assets through divestitures or pursing structures and partnerships
- Continuing to safeguard our financial assets through attainment of further efficiencies, increased transparency and ensure full integration with our balance sheet

Consumerization

Extending our Ambulatory network

We are expanding our ambulatory care network through organic and inorganic growth strategies, new outpatient centers, corporate development activities, and strategic partnerships. Our ambulatory network is comprised of 32 ambulatory care centers, 39 imaging centers, 55 urgent care centers, 34 retail clinics, and over 700 primary and specialty clinics. We believe ambulatory networks offer advantages to patients and physicians, including greater affordability, predictability, flexibility, and convenience. Due to advancements in medical technology, the lower cost structure and greater efficiencies that are attainable in a specialized outpatient facility. We believe the volume and complexity of surgical cases performed in an outpatient setting will continue to steadily increase. We are evolving our care model for the future by providing patients with consumer-oriented, lower cost options for virtual and at-home care that provide greater ease of access.

Population Health

Transforming care and improving population outcomes

Population Health models and initiatives form a vital pillar in achieving our strategic plan of creating healthier communities, together. Our goal is to maximize the health outcomes of the people in our defined populations and communities through the design, delivery, and coordination of affordable quality health care. In 2017, our health plan served over one million patients and was one of only 23 plans nationally to achieve 5-Star Medicare Health Plan Quality Status which represents our commitment to value-based care delivery. We are focused on the social determinants of health, including access to care and services, reliable transportation, housing, education, and nutrition, and by building partnerships that involve care management, housing, community services, and increased access.

Scientific Wellness

Aligning biomedical innovation with real world clinical practice

We are pioneering predictive modeling through our research affiliate, the Institute for Systems Biology, a biomedical research organization comprised of a cross-disciplinary team of scientists with expertise in biology, technology, computer science, engineering, and bioinformatics. The ISB consists of 185 full-time staff from 30 countries, produced over 1,300 research publications since 2000, ranked 4th in the world for research impact, and has generated over $364 million in grants and contracts revenue. Through ISB, we have formed partnerships, most recently with Seattle startup Arivale to explore how data-driven lifestyle coaching can prevent the advancement of Alzheimer's or reverse early symptoms of the disease. We seek to take a systems-driven approach to optimize health and predict and prevent disease, and enable a sustainable environment in the communities we serve and nationally.

Data and Digital Innovation

Rapid proliferation of data, advanced analytics and digital technology

We are investing in a fully integrated patient system to leverage technology that allows us to operate more effectively across regions and ministries, surfaces and socializes best practices, and identifies trends and opportunities across the system. We expect cost savings as standardizations continue across all ministries and anticipate these improvements will also allow our caregivers to serve our patients more efficiently. The

renewal and expansion of our core platform represents our dedication to enhancing the patient experience across the continuum of care.

Bringing together technology and digital innovation with health care delivery

We work to bring health care into the digital and consumer age with the goal of better serving patients and consumers by delivering care on their terms. We believe digital engagement increases the patient's access to care by creating a continuous relationship with patients between episodes of care and expanding beyond our existing markets. We offer the following direct-to-customer products to engage patients:

- Express Care is a digital platform that enables on-demand patient access to Express Care retail clinics, telehealth, or at-home visits through the web or mobile apps
- The Circle™ is a mobile women's health platform that delivers relevant content, products and services on pregnancy and pediatrics
- Xealth™ allows physicians to prescribe digital content, apps and services to patients through electronic medical records
- Optimal Aging™ provides seniors with affordable access to non-clinical services such as transportation, meals, home care and other lifestyle necessities

"Growth through access, convenience, and personalization is a great first step in digitally enabling our health system to deliver modernized, frictionless care to our patients."
-Aaron Martin, Executive Vice President and Chief Digital Officer

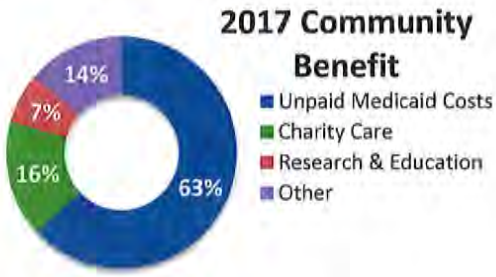
SWEDISH EXPRESS CARE VIRTUAL | PROVIDENCE Express Care at Walgreens | PROVIDENCE Express Care at Home | circle | xealth

Community Benefit

Sustaining our Mission by investing in our communities

We have a deep rooted history of reaching out to those in need, working to bring hope, health and healing to those we serve. As a faith-based, not-for-profit health and social services system, our commitment to community is realized, in part, through community programs and services that:

- Promote health and well-being
- Extend care to those poor and vulnerable who lack coverage from the U.S. healthcare finance system
- Support health professions education aimed at increasing the health care workforce
- Provide free and discounted medical care through our Financial Assistance Program



In each of the past two years, we have invested over $1.6 billion per year in community benefit demonstrating our commitment to the communities we serve. In an environment of decreased reimbursement for government sponsored medical care, Medicaid shortfall, after accounting for government reimbursement, was $1.0 billion, the total community benefit in both 2017 and 2016. We recognize that health begins in our homes, schools, workplaces, neighborhood, and communities.

Introduction to Management's Discussion and Analysis

Management's discussion and analysis provides additional narrative explanation of the financial condition, operational results and cash flow of the System to assist in understanding the combined financial statements. The following information should be read in conjunction with the audited combined financial statements of the System, including the notes thereto, and the report of KPMG LLP, independent auditors.

Leadership in the Health Care Industry

We announced the selection of **Venkat Bhamidipati**, formerly of Microsoft, as Executive Vice President and Chief Financial Officer in 2017 overseeing finance, as well as real estate, treasury, supply chain, and revenue cycle.

Principles of Consolidation

The audited combined financial information as of and for the twelve-month period ended December 31, 2017, presented below, has been derived by the System's management from the audited financial information. The unaudited pro forma combined financial information presented below of the System for the twelve-month period ended December 31, 2016 have been derived by combining the consolidated year-to-date results of Providence Health & Services and St. Joseph Health assuming that operations of the two organizations were combined as of January 1, 2016. Acquisition-related adjustments are included in the results as of the date of acquisition of July 1, 2016.

Results of Operations

Consolidated Statements of Operations

DATA PRESENTED YEAR TO DATE; PRESENTED IN MILLIONS	12-31-17	*Pro Forma* 12-31-16	VARIANCE	VARIANCE %
Net Patient Service Revenue	17,867	17,296	571	3%
Premium and Capitation Revenue	4,079	3,773	306	8%
Other Revenue	1,217	1,088	129	12%
Total Operating Revenue	**23,163**	**22,157**	**1,006**	**5%**
Salaries, Wages and Other	21,853	21,111	742	4%
Depreciation	1,038	1,036	2	0%
Interest and Amortization	269	265	4	2%
Total Operating Expenses	**23,160**	**22,412**	**748**	**3%**
Excess (Deficit) of Revenues Over Expenses from Operations	3	(255)	258	(101%)
Net Non-operating (Losses) Gains	777	378	399	106%
Contributions from Affiliations and loss on extinguishment of debt	0	5,108	(5,108)	(100%)
Excess of Revenues Over Expenses	**780**	**5,231**	**(4,451)**	**(85%)**
Operating EBIDA	**1,310**	**1,046**	**264**	**25%**

Consolidated Balance Sheets

PRESENTED IN MILLIONS	12-31-17	12-31-16	VARIANCE	VARIANCE %
ASSETS				
Current Assets:				
Cash and Cash Equivalents	1,371	1,000	371	37%
Short-term Investments	414	657	(243)	(37%)
Accounts Receivable, Net	2,222	2,206	16	1%
Supplies Inventory at Cost	277	279	(2)	(1%)
Other Current Assets	1,157	1,169	(12)	(1%)
Current Portion of Funds Held by Trustee	66	109	(43)	(39%)
Total Current Assets	**5,507**	**5,420**	**87**	**2%**
Assets Whose Use Is Limited:				
Long-term Investments	9,526	8,341	1,185	14%
Gift, Annuity, Trust and Other	181	131	50	38%
Funds Held by Trustee	279	259	20	8%
Total Assets Whose Use Is Limited	**9,986**	**8,731**	**1,255**	**14%**
Property, Plant & Equipment, Net	10,955	11,022	(67)	(1%)
Total Other Assets	1,197	1,118	79	7%
Total Assets	**27,645**	**26,291**	**1,354**	**5%**
LIABILITIES AND NET ASSETS				
Current Liabilities:				
Master Trust Debt classified as Short-term	57	153	(96)	(63%)
Accounts Payable	684	632	52	8%
Accrued Compensation	1,111	1,104	7	1%
Payable to Contractual Agencies	122	197	(75)	(38%)
Other Current Liabilities	2,169	1,666	503	30%
Current Portion of Long-term Debt	78	200	(122)	(61%)
Total Current Liabilities	**4,221**	**3,952**	**269**	**7%**
Long-term Debt, Net of Current Portion	6,485	6,396	89	1%
Other Long-term Liabilities	2,193	2,147	46	2%
Total Liabilities	**12,899**	**12,495**	**404**	**3%**
Net Assets:				
Unrestricted	13,545	12,760	785	6%
Temporarily Restricted	958	816	142	17%
Permanently Restricted	243	220	23	10%
Total Net Assets	**14,746**	**13,796**	**950**	**7%**
Total Liabilities and Net Assets	**27,645**	**26,291**	**1,354**	**5%**

Operating income was $3 million for the year ended December 31, 2017, compared with an operating loss of $255 million in the prior year. Operating earnings before interest, depreciation and amortization ("EBIDA") increased to $1.3 billion for the year ended December 31, 2017, compared with $1 billion over the prior year. Operating EBIDA includes a $133 million gain related to the sale of Pathology Associates Medical Laboratories, LLC in 2017 which balanced a $90 million decline related to approval delays for the managed care portion of the California provider tax program. Excluding these items, operating EBIDA increased to $1.2 billion, or 21 percent for the year ended December 2017, compared with $956 million over the prior year, primarily driven by expense reduction efforts and higher volumes. The table below provides key financial indicators for the periods indicated:

DATA PRESENTED YEAR TO DATE; $ FIGURES PRESENTED IN MILLIONS	12-31-17	*Pro Forma* 12-31-16	VARIANCE	VARIANCE %
Operating Margin %	0.0	(1.2)	1.2	100%
Operating EBIDA Margin %	5.7	4.7	1.0	21%
Total Community Benefit	1,601	1,632	(31)	(2%)
Net Service Revenue/Case Mix Adjusted Admits	11,652	11,817	(165)	(1%)
Expense/Case Mix Adjusted Admits	11,650	11,976	(326)	(3%)
Full-time Equivalents (thousands)	103	102	1	1%

Volume Trends

The System's core strategy of delivering outstanding, affordable health care led to higher volumes in 2017 compared with the prior year. This growth was largely driven by outpatient activity and higher acuity within the acute setting as measured by case mix index which increased four percent for the year ended December 31, 2017, compared with the prior year. Outpatient visits grew five percent, primarily driven by an eight percent increase in surgeries including 13 percent growth in the outpatient setting for the year ended December 31, 2017. The table below provides key volume indicators for the periods indicated:

DATA PRESENTED YEAR TO DATE; IN THOUSANDS UNLESS NOTED	12-31-17	*Pro Forma* 12-31-16	VARIANCE	VARIANCE %
Inpatient Admissions	522	526	(4)	(1%)
Acute Adjusted Admissions	1,002	989	13	1%
Acute Patient Days	2,420	2,387	33	1%
Long-term Patient Days	399	400	(1)	0%
Outpatient Visits (incl. Physicians)	25,648	24,352	1,296	5%
Emergency Room Visits	2,119	2,124	(5)	0%
Total Surgeries	613	567	46	8%
Acute Average Daily Census	6,631	6,522	109	2%
Providence Health Plan Members	648	639	9	1%

The Providence Health Plan enrollment grew one percent compared with the prior year. Connected lives member months, a measure of coverage for insured members, were 8 million for the Providence Health Plan, an increase of 2 percent for the year ended December 31, 2017, compared with the prior year.

Operating Revenue

Operating revenue for the year ended December 31, 2017 was $23 billion, an increase of five percent compared with the prior year due primarily to volumes growth. Capitation and premium revenue, representing 18 percent of total operating revenue, grew eight percent during the year ended December 31, 2017, compared with the prior year. The System's operating revenue share by geographic region for the year ended December 31, 2017 is shown in the table below for the periods indicated:

REGIONAL OPERATING REVENUE SHARE	12-31-17	*Pro Forma* 12-31-16	VARIANCE
Alaska	4%	4%	0%
Swedish	11%	12%	(1%)
Washington and Montana	20%	20%	0%
Oregon	21%	20%	1%
Northern California	6%	6%	0%
Southern California	29%	29%	0%
Texas	6%	7%	(1%)
Other	3%	2%	1%

The System's operating revenue share by line of business for the year ended December 31, 2017 is shown in the table below for the periods indicated:

SEGMENT OPERATING REVENUE SHARE	12-31-17	*Pro Forma* 12-31-16	VARIANCE
Hospitals	71%	72%	(1%)
Health Plans and Accountable Care	12%	11%	1%
Physician and Outpatient Activities	12%	12%	0%
Continuum Services	5%	5%	0%

Net patient revenue per case mix adjusted admissions declined one percent for the year ended December 31, 2017, on a reported basis; however, grew 2 percent when adjusting for the timing of the provider fee in California despite lower commercial mix. The System's net patient revenue by payor mix is shown in the table below for the periods indicated:

PAYOR NET PATIENT REVENUE SHARE	12-31-17	*Pro Forma* 12-31-16	VARIANCE
Commercial	50%	51%	(1%)
Medicare	33%	32%	1%
Medicaid	14%	15%	(1%)
Self-pay and Other	3%	2%	1%

Operating Expenses

Operating expenses for the year ended December 31, 2017 were $23 billion, an increase of three percent compared with the prior year, driven mainly by costs to serve higher volumes. The increase was nearly two points lower than revenue growth due to productivity improvements and the realization of synergies from the System's affiliation in 2016. Salaries and wages expense increased four percent for the year ended December 31, 2017, compared with the prior year, driven by full-time equivalent growth, and higher wage rates and benefit costs, while supplies expense increased four percent from higher volumes, pharmaceutical spend, and a shift into procedures leveraging new technologies.

Non-Operating Income

Non-operating income is primarily comprised of investment gains and losses, pension settlement costs and innovation projects and expense. Non-operating income included a combined net gain of $5 billion in 2016, from affiliation and subsequent debt restructuring. Excluding the impact of gains related to the affiliation and debt refinancing, non-operating income increased to $777 million for the year ended December 31, 2017, compared with $378 million in the prior year, driven by strong investment performance.

Liquidity and Capital Resources

Financial Ratios

The table below includes the System's financial ratios for the periods indicated:

DATA PRESENTED YEAR TO DATE; $ FIGURES PRESENTED IN MILLIONS	12-31-17	*Pro Forma* 12-31-16	VARIANCE
Debt to Capitalization %	32.6	33.9	(1.3)
Debt Service Coverage	3.3	2.7	0.6
Cash to Debt Ratio %	172.9	148.8	24.1
Operating Cash Flow Margin %	5.7	4.7	1.0
Cash to Comprehensive Debt %	114.4	98.3	16.1
Debt to Cash Flow	3.1	4.6	(1.5)
Cushion Ratio	29	25	4
Maximum Annual Debt Service	384	389	(5)
Comprehensive Debt to Capitalization %	42.2	43.7	(1.5)
Cash to Total Net Asset Ratio	0.84	0.76	0.08

Unrestricted Cash and Investments

Unrestricted cash reserves totaled $11.3 billion as of December 31, 2017 compared to $9.7 billion in the prior year driven primarily by investment gains, partially offset by payments related to pension obligations, debt service costs, and capital expenditures. Days of cash on hand, a measure of cash in relation to monthly operating expenses, was 187 days at December 31, 2017, an improvement of 19 days compared with the prior year, primarily driven by increases in investment income.

Credit Agency Ratings

The System received affirmation on the following ratings from the three national credit rating agencies conducted during their annual review in 2017 and issued the following credit ratings:

- Fitch: "AA-"
- Standard and Poor's: "AA-"
- Moody's: "Aa3"

Subsequent Events

Plan of Finance

In February 2018, the System closed on its 2018 plan of finance which included $350 million of taxable debt and $142 million in fixed rate tax-exempt debt for the System and its affiliates. The proceeds will be used primarily to refinance existing bonds and draws on existing lines of credit. The bonds also finance a small portion of new debt and prior series of debt.

Financial Performance Crosswalk

As noted previously, certain results discussed in this document are presented on a pro forma basis for the System. The tables below represent a comparison of the combined pro forma data for the year ended December 31, 2016 versus the audited results of the System, which includes St. Joseph Health financial results from the effective date of the affiliation of July 1, 2016. The difference represents activity from January 1, 2016 to June 30, 2016, which was prior to the effective date of the affiliation.

Statements of Operations	12-31-2016	
DATA PRESENTED YEAR TO DATE; $ FIGURES PRESENTED IN MILLIONS	Pro Forma	Audited
Net Patient Revenue	17,296	14,769
Premium and Capitation Revenue	3,773	3,105
Other Revenue	1,088	1,005
Total Revenue	**22,157**	**18,879**
Salaries and Wages	8,926	7,788
Depreciation	1,036	851
Interest and Amortization	265	215
Other Expenses	12,185	10,274
Total Operating Expenses	**22,412**	**19,128**
Excess of Revenues Over Expenses from Operations	(255)	(249)
Net Non-operating (Losses) Gains	5,486	5,480
Excess of Revenues Over Expenses	**5,231**	**5,231**

Obligated Group

During the year ended December 31, 2017, the audited combined net operating revenue and total assets attributable to the Obligated Group Members were approximately 83.0% and 88.2%, respectively, of the System totals. For the year ended December 31, 2016, the unaudited pro forma combined net operating revenues and total assets attributable to the Obligated Group Members were approximately 78.8% and 90.5%, respectively, of the Systems totals. The following exhibits are voluntary supplemental information on the Obligated Group Members.

Providence St.Joseph Health

EXHIBIT A.1 - SUMMARY AUDITED AND UNAUDITED PRO FORMA COMBINED STATEMENTS OF OPERATION

	Ended December 31, 2017 (in 000's of dollars)		*Pro Forma* Ended December 31, 2016 (in 000's of dollars)	
	Consolidated	Obligated	Consolidated	Obligated
Operating Revenue:				
Net Service Revenue	$ 17,866,609	$ 17,387,036	$ 17,296,033	$ 15,634,509
Premium and Capitation Revenue	4,079,290	772,317	3,773,289	920,446
Other Operating Revenue	1,217,346	1,071,744	1,087,711	906,984
Net Operating Revenues	23,163,245	19,231,097	22,157,033	17,461,939
Operating Expenses:				
Salaries, Wages and Benefits	11,464,879	10,391,082	11,028,633	9,411,158
Supplies	3,389,917	3,194,180	3,260,563	2,811,508
Depreciation Expense	1,037,984	974,623	1,036,273	873,016
Interest and Amortization	269,042	257,793	265,036	225,025
Other Expenses	6,998,330	3,826,726	6,821,429	3,964,044
Total Operating Expenses	23,160,152	18,644,404	22,411,934	17,284,751
Excess (Deficit) of Rev Over Exp from Operations	3,093	586,693	(254,901)	177,188
Net Non-operating (Losses) Gains	776,859	769,305	5,484,963	81,254
Excess of Revenue Over Expenses	$ 779,952	$ 1,355,998	$ 5,230,062	$ 258,442

EXHIBIT A.2 - SUMMARY AUDITED AND UNAUDITED PRO FORMA COMBINED STATEMENTS OF CASH FLOW

	Ended December 31, 2017 (in 000's of dollars)		*Pro Forma* Ended December 31, 2016 (in 000's of dollars)	
	Consolidated	Obligated	Consolidated	Obligated
Net cash provided by (used in) operating activities	$ 1,268,066	$ 2,314,246	$ 1,006,944	$ 1,169,294
Net cash provided by (used in) investing activities	(1,027,427)	(814,554)	(1,195,392)	(929,188)
Net cash provided by (used in) financing activities	130,363	(1,263,649)	303,187	(134,743)
Increase in cash and cash equivalents	371,002	236,043	114,739	105,363
Cash and cash equivalents, beginning of period	1,000,187	550,883	885,448	445,520
Cash and cash equivalents, end of period	$ 1,371,189	$ 786,926	$ 1,000,187	$ 550,883

EXHIBIT A.3 - SUMMARY AUDITED AND UNAUDITED PRO FORMA NET PATIENT REVENUE PAYOR MIX

	Ended December 31, 2017 (in 000's of dollars)		*Pro Forma* Ended December 31, 2016 (in 000's of dollars)	
	Consolidated	Obligated	Consolidated	Obligated
Commercial	50%	50%	51%	48%
Medicare	33%	33%	32%	33%
Medicaid	14%	15%	15%	16%
Self-pay and Other	3%	2%	2%	3%

Providence St.Joseph Health

EXHIBIT A.4 - SUMMARY AUDITED AND UNAUDITED COMBINED BALANCE SHEETS

	As of December 31, 2017 (in 000's of dollars)		As of December 31, 2016 (in 000's of dollars)	
	Consolidated	Obligated	Consolidated	Obligated
Current Assets:				
Cash and Cash Equivalents	$ 1,371,189	$ 786,926	$ 1,000,187	$ 550,883
Short-term Management Designated Investments	413,700	254,383	657,392	487,902
Accounts Receivable, Net	2,221,520	2,147,724	2,206,313	2,122,934
Other Current Assets	1,434,329	1,373,457	1,447,967	1,644,012
CP of Assets-Use is Limited	66,242	1,532	108,839	3,476
Total Current Assets	5,506,980	4,564,022	5,420,698	4,809,207
Assets Whose Use is Limited:				
Management Designated Cash and Investments	9,525,490	7,168,794	8,190,080	6,525,727
Funds Held by Trustee, Gift Annuity, and Other	460,361	411,613	541,030	294,214
Assets Whose Use is Limited	9,985,851	7,580,407	8,731,110	6,819,941
Property Plant Equipment Net	10,955,120	10,495,562	11,022,371	10,561,025
Total Other Long-term Assets	1,196,723	1,732,368	1,117,521	1,594,830
Total Assets	$ 27,644,674	$ 24,372,359	$ 26,291,700	$ 23,785,003
Current Liabilities:				
Short-term Debt	$ 56,676	$ 56,675	$ 153,350	$ 153,350
Accounts Payable	684,382	623,661	632,240	506,281
Accrued Compensation	1,110,682	1,033,090	1,104,376	1,025,646
Other Current Liabilities	2,369,876	1,699,368	2,062,386	1,483,963
Total Current Liabilities	4,221,616	3,412,794	3,952,352	3,169,240
Long Term Debt	6,484,528	6,457,366	6,396,089	6,376,495
Total Other Long-term Liabilities	2,193,453	1,562,861	2,148,641	1,653,888
Total Liabilities	12,899,597	11,433,021	12,497,082	11,199,623
Net Assets:				
Unrestricted	13,544,700	12,177,980	12,759,330	11,921,608
Restricted Net Assets	1,200,377	761,358	1,035,288	663,772
Total Net Assets	14,745,077	12,939,338	13,794,618	12,585,380
Total Liabilities and Net Assets	$ 27,644,674	$ 24,372,359	$ 26,291,700	$ 23,785,003

Providence St.Joseph Health

EXHIBIT A.5 - KEY PERFORMANCE METRICS

	Ended December 31, 2017		*Pro Forma* Ended December 31, 2016	
	Consolidated	Obligated	Consolidated	Obligated
Total Acute Admissions	522,153	516,227	526,342	520,368
Total Acute Patient Days	2,420,196	2,391,407	2,387,172	2,358,776
Acute Outpatient Visits	12,353,677	11,759,499	12,184,611	11,598,565
Primary Care Visits	12,127,920	8,345,993	11,193,978	7,703,288
Inpatient Surgeries	226,149	221,487	224,287	219,663
Outpatient Surgeries	386,881	336,140	342,323	297,426
Long-Term Care Patient Days	398,917	387,459	400,031	388,541
Home Health Visits	1,166,858	793,982	972,973	662,054
Hospice Days	869,064	611,544	835,183	587,703
Housing and Assisted Living Days	612,698	248,169	579,503	234,724
Health Plan Members	818,640	n/a	825,331	n/a
Total Average Daily Census	6,631	6,552	6,522	6,445
Total Acute Licensed Beds	11,817	11,747	11,915	11,844
FTEs	103,058	93,326	101,846	92,229

Providence St. Joseph Health

EXHIBIT B.1 - SUMMARY AUDITED COMBINING STATEMENTS OF OPERATIONS BY REGION

	Ended December 31, 2017 (in 000's of dollars)								
	Alaska	Swedish	Washington/ Montana	Oregon	Northern California	Southern California	Texas	Other/ Eliminations	Consolidated
Operating Revenue:									
Net Service Revenue	$ 817,706	$ 2,515,900	$ 4,160,401	$ 2,436,046	$ 1,303,771	$ 5,427,279	$ 840,490	$ 365,016	$ 17,866,609
Premium and Capitation Revenue	0	0	147,187	2,130,582	57,321	1,129,600	565,894	48,706	4,079,290
Other Operating Revenue	58,597	133,740	221,781	255,367	45,747	215,769	67,679	218,666	1,217,346
Net Operating Revenues	876,303	2,649,640	4,529,369	4,821,995	1,406,839	6,772,648	1,474,063	632,388	23,163,245
Operating Expenses:									
Salaries, Wages and Benefits	331,122	1,255,344	2,047,093	1,556,464	663,314	2,806,823	516,049	2,288,670	11,464,879
Supplies	110,938	440,805	744,140	470,519	194,994	983,151	192,158	253,212	3,389,917
Depreciation Expense	49,105	113,130	134,587	111,250	56,136	280,948	45,273	247,555	1,037,984
Interest and Amortization	11,848	46,551	52,021	8,001	14,695	92,482	5,730	37,714	269,042
Other Expenses	285,807	816,605	1,527,013	2,590,732	450,292	2,786,618	663,692	(2,122,429)	6,998,330
Total Operating Expenses	788,820	2,672,435	4,504,854	4,736,966	1,379,431	6,950,022	1,422,902	704,722	23,160,152
Excess (Deficit) of Revenue Over Expenses from Operations	87,483	(22,795)	24,515	85,029	27,408	(177,374)	51,161	(72,334)	3,093
Net Non-operating (Losses) Gains	52,897	62,000	71,779	125,553	45,142	307,334	10,220	101,934	776,859
Excess of Revenue Over Expenses	$ 140,380	$ 39,205	$ 96,294	$ 210,582	$ 72,550	$ 129,960	$ 61,381	$ 29,600	$ 779,952

Providence St. Joseph Health

EXHIBIT B.2 - SUMMARY AUDITED COMBINING BALANCE SHEETS BY REGION

	As of December 31, 2017 (in 000's of dollars)								
	Alaska	Swedish	Washington/ Montana	Oregon	Northern California	Southern California	Texas	Other/ Eliminations	Consolidated
Current Assets:									
Cash and Cash Equivalents	$ 172,414	$ 85,792	$ 192,357	$ 98,938	$ 34,153	$ 426,649	$ 127,832	$ 233,054	$ 1,371,189
Short-term Management Designated Investments	0	0	0	0	3,886	17,072	1,751	390,991	413,700
Accounts Receivable, Net	129,985	332,753	504,673	262,072	157,389	684,480	137,388	12,780	2,221,520
Other Current Assets	367,048	167,459	522,578	494,068	90,966	(215,097)	74,202	(66,895)	1,434,329
Current Portion of Assets-Use is Limited	0	0	0	0	0	0	0	66,242	66,242
Total Current Assets	669,447	586,004	1,219,608	855,078	286,394	913,104	341,173	636,172	5,506,980
Assets Whose Use is Limited:									
Management Designated Cash and Investments	570,509	565,955	754,354	1,914,016	429,130	2,812,208	129,126	2,350,192	9,525,490
Funds Held by Trustee, Gift Annuity, and Other	282	14,453	4,890	136,679	14,317	43,419	3,939	242,382	460,361
Assets Whose Use is Limited	570,791	580,408	759,244	2,050,695	443,447	2,855,627	133,065	2,592,574	9,985,851
Property Plant Equipment Net	491,645	1,343,130	1,719,598	1,082,050	648,258	3,734,530	409,364	1,526,545	10,955,120
Total Other Long-term Assets	24,009	112,668	198,605	29,446	13,725	480,184	55,184	282,902	1,196,723
Total Assets	$ 1,755,892	$ 2,622,210	$ 3,897,055	$ 4,017,269	$ 1,391,824	$ 7,983,445	$ 938,786	$ 5,038,193	$ 27,644,674
Current Liabilities:									
Short-term Debt	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 56,676	$ 56,676
Accounts Payable	14,640	53,475	96,666	79,169	37,153	211,828	22,123	169,328	684,382
Accrued Compensation	29,882	85,817	170,726	127,426	47,975	286,559	40,628	321,669	1,110,682
Other Current Liabilities	7,341	142,561	352,550	409,666	147,357	674,285	78,489	557,627	2,369,876
Total Current Liabilities	51,863	281,853	619,942	616,261	232,485	1,172,672	141,240	1,105,300	4,221,616
Long Term Debt	259,066	1,034,008	1,185,976	210,619	360,810	2,133,335	150,191	1,150,523	6,484,528
Total Other Long-term Liabilities	22,889	436,712	38,671	40,279	7,444	188,987	36,664	1,421,807	2,193,453
Total Liabilities	333,818	1,752,573	1,844,589	867,159	600,739	3,494,994	328,095	3,677,630	12,899,597
Net Assets:									
Unrestricted	1,407,926	791,576	1,988,958	2,984,100	733,280	3,836,659	574,543	1,227,658	13,544,700
Restricted Net Assets	14,148	78,061	63,508	166,010	57,805	651,792	36,148	132,905	1,200,377
Total Net Assets	1,422,074	869,637	2,052,466	3,150,110	791,085	4,488,451	610,691	1,360,563	14,745,077
Total Liabilities and Net Assets	$ 1,755,892	$ 2,622,210	$ 3,897,055	$ 4,017,269	$ 1,391,824	$ 7,983,445	$ 938,786	$ 5,038,193	$ 27,644,674

Providence St. Joseph Health

EXHIBIT B.3 - KEY PERFORMANCE METRICS BY REGION

	As of December 31, 2017							
	Alaska	Swedish	Washington/ Montana	Oregon	Northern California	Southern California	Texas	Consolidated
Total Acute Admissions	16,926	67,237	129,574	64,646	29,489	188,961	25,320	522,153
Total Acute Patient Days	111,385	300,041	638,338	301,536	157,123	781,465	130,307	2,420,196
Acute Outpatient Visits	457,418	756,935	2,816,944	3,480,608	728,962	3,573,255	539,556	12,353,677
Primary Care Visits	129,306	1,889,629	3,724,101	2,292,127	446,427	3,255,716	390,614	12,127,920
Inpatient Surgeries	8,842	32,047	59,729	31,125	8,361	77,716	8,329	226,149
Outpatient Surgeries	11,774	51,890	108,433	60,872	18,359	117,719	17,834	386,881
Long-Term Care Patient Days	58,571	n/a	14,214	44,542	n/a	82,496	11,458	398,917
Home Health Visits	13,740	n/a	27,091	303,835	53,188	396,247	n/a	1,166,858
Hospice Days	19,151	n/a	n/a	185,458	62,769	116,252	51,629	869,064
Housing and Assisted Living Days	28,936	n/a	28,137	144,528	n/a	n/a	n/a	612,698
Health Plan Members	n/a	n/a	n/a	647,781	n/a	n/a	170,859	818,640
Total Average Daily Census	305	822	1,749	826	430	2,141	357	6,631
Total Acute Licensed Beds	426	1,576	2,771	1,484	(1)	3,909	891	11,817
FTEs	3,647	10,777	20,676	15,856	4,827	27,151	5,405	103,058

KPMG

PROVIDENCE ST. JOSEPH HEALTH

Combined Financial Statements

December 31, 2017 and 2016

(With Independent Auditors' Report Thereon)

KPMG LLP
Suite 2900
1918 Eighth Avenue
Seattle, WA 98101

Independent Auditors' Report

The Board of Directors
Providence St. Joseph Health:

Report on the Financial Statements

We have audited the accompanying combined financial statements of Providence St. Joseph Health, which comprise the combined balance sheets as of December 31, 2017 and 2016, and the related combined statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the combined financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these combined financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of combined financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these combined financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the combined financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the combined financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the combined financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the combined financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the combined financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the combined financial statements referred to above present fairly, in all material respects, the financial position of St. Joseph Health as of December 31, 2017 and 2016, and the results of its operations and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

Other Matter

Our audit was conducted for the purpose of forming an opinion on the combined financial statements as a whole. The Obligated Group Combining Balance Sheets and Statements of Operations Information included on pages 33 and 34 is presented for purposes of additional analysis and is not a required part of the combined financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the combined financial statements. The information has been subjected to the auditing procedures applied in the audit of the combined financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the combined financial statements or to the combined financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the combined financial statements as a whole.

KPMG LLP

Seattle, Washington
March 7, 2018

PROVIDENCE ST. JOSEPH HEALTH

Combined Balance Sheets

December 31, 2017 and 2016

(In millions of dollars)

Assets		2017	2016
Current assets:			
Cash and cash equivalents	$	1,371	1,000
Accounts receivable, less allowance for bad debts of $227 in 2017 and $271 in 2016		2,222	2,206
Supplies inventory		277	279
Other current assets		1,157	1,169
Current portion of assets whose use is limited		480	766
Total current assets		5,507	5,420
Assets whose use is limited		9,986	8,731
Property, plant, and equipment, net		10,955	11,022
Other assets		1,197	1,118
Total assets	$	27,645	26,291
Liabilities and Net Assets			
Current liabilities:			
Current portion of long-term debt	$	78	200
Master trust debt classified as short-term		57	153
Accounts payable		684	632
Accrued compensation		1,111	1,104
Other current liabilities		2,291	1,863
Total current liabilities		4,221	3,952
Long-term debt, net of current portion		6,485	6,396
Pension benefit obligation		1,054	1,120
Other liabilities		1,139	1,027
Total liabilities		12,899	12,495
Net assets:			
Unrestricted:			
Controlling interest		13,366	12,560
Noncontrolling interest		179	200
Temporarily restricted		958	816
Permanently restricted		243	220
Total net assets		14,746	13,796
Total liabilities and net assets	$	27,645	26,291

See accompanying notes to combined financial statements.

PROVIDENCE ST. JOSEPH HEALTH

Combined Statements of Operations

Years ended December 31, 2017 and 2016

(In millions of dollars)

	2017	2016
Operating revenues:		
Net patient service revenues	$ 18,136	14,972
Provision for bad debts	(269)	(203)
Net patient service revenues less provision for bad debts	17,867	14,769
Premium revenues	2,745	2,240
Capitation revenues	1,334	865
Other revenues	1,217	1,005
Total operating revenues	23,163	18,879
Operating expenses:		
Salaries and benefits	11,464	9,599
Supplies	3,390	2,788
Purchased healthcare services	2,539	1,917
Interest, depreciation, and amortization	1,307	1,066
Purchased services, professional fees, and other	4,460	3,758
Total operating expenses	23,160	19,128
Excess (deficit) of revenues over expenses from operations	3	(249)
Net nonoperating gains (losses):		
Contributions from affiliations	—	5,167
Loss on extinguishment of debt	—	(60)
Investment income, net	882	403
Other	(105)	(30)
Total net nonoperating gains	777	5,480
Excess of revenues over expenses	$ 780	5,231

See accompanying notes to combined financial statements.

PROVIDENCE ST. JOSEPH HEALTH

Combined Statements of Changes in Net Assets

Years ended December 31, 2017 and 2016

(In millions of dollars)

	Unrestricted				
	controlling interest	noncontrolling interest	Temporarily restricted	Permanently restricted	Total net assets
Balance, December 31, 2015	$ 7,542	45	325	124	8,036
Excess of revenues over expenses	5,093	138	—	—	5,231
Restricted contributions from affiliations	—	—	405	91	496
Contributions, grants, and other	(13)	17	145	5	154
Net assets released from restriction	19	—	(59)	—	(40)
Pension related changes	(81)	—	—	—	(81)
Increase in net assets	5,018	155	491	96	5,760
Balance, December 31, 2016	12,560	200	816	220	13,796
Excess of revenues over expenses	747	33	—	—	780
Contributions, grants, and other	(43)	(54)	222	23	148
Net assets released from restriction	44	—	(80)	—	(36)
Pension related changes	58	—	—	—	58
Increase (decrease) in net assets	806	(21)	142	23	950
Balance, December 31, 2017	$ 13,366	179	958	243	14,746

See accompanying notes to combined financial statements.

PROVIDENCE ST. JOSEPH HEALTH

Combined Statements of Cash Flows

Years ended December 31, 2017 and 2016

(In millions of dollars)

	2017	2016
Cash flows from operating activities:		
Increase in net assets	$ 950	5,760
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Contributions from affiliations	—	(5,663)
Gain on divestiture	(133)	—
Depreciation and amortization	1,057	860
Provision for bad debt	269	203
Loss on extinguishment of debt	—	60
Restricted contributions and investment income received	(245)	(150)
Net realized and unrealized gains on investments	(761)	(316)
Changes in certain current assets and current liabilities	166	13
Change in certain long-term assets and liabilities	(35)	26
Net cash provided by operating activities	1,268	793
Cash flows from investing activities:		
Property, plant, and equipment additions	(1,009)	(967)
Sales of trading securities, net	18	68
Purchases of alternative investments and commingled funds	(551)	(466)
Proceeds from sales of alternative investments and commingled funds	367	153
Cash acquired through affiliation and divestiture activities, net of cash paid	114	367
Other investing activities	34	49
Net cash used in investing activities	(1,027)	(796)
Cash flows from financing activities:		
Proceeds from restricted contributions and restricted income	245	150
Debt borrowings	376	3,606
Debt payments	(483)	(3,474)
Other financing activities	(8)	(8)
Net cash provided by financing activities	130	274
Increase in cash and cash equivalents	371	271
Cash and cash equivalents, beginning of year	1,000	729
Cash and cash equivalents, end of year	$ 1,371	1,000
Supplemental disclosure of cash flow information:		
Cash paid for interest (net of amounts capitalized)	$ 245	191

See accompanying notes to combined financial statements.

(1) Basis of Presentation and Significant Accounting Policies

(a) Reporting Entity

Providence St. Joseph Health (the Health System) is a Washington nonprofit corporation that became the sole corporate member of Providence Health & Services (PHS) and the St. Joseph Health System (SJHS) as of July 1, 2016. PHS, a Washington nonprofit corporation, is a Catholic healthcare system sponsored by the public juridic person, Providence Ministries. SJHS, a California nonprofit public benefit corporation, is a Catholic healthcare system sponsored by the public juridic person, St. Joseph Health Ministry. The business combination of PHS and SJHS, through the alignment under the Health System, qualified for acquisition accounting with PHS as the acquirer of SJHS.

The Health System seeks to improve the health of the communities it serves, especially the poor and vulnerable. The Health System operations includes 50 hospitals and a comprehensive range of services provided across Alaska, California, Montana, New Mexico, Oregon, Texas, and Washington. The Health System also provides population health management through various affiliated licensed insurers and other risk-bearing entities.

The Health System has been recognized as exempt from federal income taxes, except on unrelated business income, under Section 501(a) of the Internal Revenue Code (IRC) as an organization described in Section 501(c)(3) and further described as a public charitable organization under Section 509(a)(3). PHS, SJHS, and substantially all of the various corporations within the Health System have been granted exemptions from federal income tax under Section 501(a) of the Internal Revenue Code as charitable organizations described in Section 501(c)(3). During 2017 and 2016, the Health System did not record any liability for unrecognized tax benefits.

The accompanying combined balance sheets and related combined statements of operations, changes in nets assets, and cash flows reflect the Health System financial position and results of operations as of and for the year ended December 31, 2017. The Health System results of operations for the year ended December 31, 2016 include twelve months of results of operations for PHS and six months of results of operations for SJHS subsequent to acquisition.

(b) Basis of Presentation

The accompanying combined financial statements of the Health System were prepared in accordance with U.S. generally accepted accounting principles and include the assets, liabilities, revenues, and expenses of all wholly owned affiliates, majority-owned affiliates over which the Health System exercises control, and, when applicable, entities in which the Health System has a controlling financial interest.

Intercompany balances and transactions have been eliminated in combination.

(c) Performance Indicator

The performance indicator is the excess of revenues over expenses. Changes in unrestricted net assets that are excluded from the performance indicator include net assets released from restriction for the purchase of property plant and equipment, certain changes in funded status of pension and other

(Continued)

postretirement benefit plans, restricted contributions from affiliations, net changes in noncontrolling interests in combined joint ventures, and certain other activities.

(d) Operating and Nonoperating Activities

The Health System's primary mission is to meet the healthcare needs in its market areas through a broad range of general and specialized healthcare services, including inpatient acute care, outpatient services, physician services, long-term care, population health management, and other healthcare and health insurance services. Activities directly associated with the furtherance of this mission are considered to be operating activities. Other activities that result in gains or losses peripheral to the Health System's primary mission are considered to be nonoperating. Nonoperating activities include investment earnings, gains or losses from debt extinguishment, certain pension related costs, gains or losses on interest rate swaps, contributions from affiliations, and certain other activities.

(e) Use of Estimates and Assumptions

The preparation of the combined financial statements in conformity with U.S. generally accepted accounting principles requires the use of estimates and assumptions that affect the reported amounts of assets and liabilities and the reported amounts of revenues and expenses during the reporting periods. Significant estimates and assumptions are used for, but not limited to: (1) allowance for contractual revenue adjustments; (2) allowance for doubtful accounts; (3) fair value of acquired assets and assumed liabilities in business combinations; (4) fair value of investments; (5) reserves for self-insured healthcare plans; and (6) reserves for professional, workers' compensation and general insurance liability risks.

The accounting estimates used in the preparation of the combined financial statements will change as new events occur, additional information is obtained or the operating environment changes. Assumptions and the related estimates are updated on an ongoing basis and external experts may be employed to assist in the evaluation, as considered necessary. Actual results could materially differ from those estimates.

(f) Cash and Cash Equivalents

Cash and cash equivalents include highly liquid investments with an original or remaining maturity of three months or less when acquired.

(g) Supplies Inventory

Supplies inventory is stated at the lower of cost (first-in, first-out) or market.

(h) Property, Plant, and Equipment

Property, plant, and equipment are stated at cost. Improvements and replacements of plant and equipment are capitalized, maintenance and repairs are expensed. The provision for depreciation is determined by the straight-line method, which allocates the cost of tangible property equally over its estimated useful life or lease term. Impairment of property, plant, and equipment is assessed when there is evidence that events or changes in circumstances have made recovery of the net carrying value of assets unlikely.

(In millions of dollars)

Interest capitalized on amounts expended during construction is a component of the cost of additions to be allocated to future periods through the provision for depreciation. Capitalization of interest ceases when the addition is substantially complete and ready for its intended use.

Property, plant, and equipment and the total accumulated depreciation are as follows as of December 31:

	Approximate useful life (years)	2017	2016
Land	—	$ 1,465	1,451
Buildings and improvements	5–60	9,714	9,434
Equipment:			
Fixed	5–25	1,278	1,254
Major movable and minor	3–20	5,833	5,470
Construction in progress	—	1,030	870
		19,320	18,479
Less accumulated depreciation		(8,365)	(7,457)
Property, plant, and equipment, net		$ 10,955	11,022

Construction in progress primarily represents renewal and replacement of various facilities in the Health System's operating divisions, as well as costs capitalized to software development.

(i) Other Assets

Other assets primarily consist of investments in nonconsolidated joint ventures, beneficial interest in noncontrolled foundations, notes receivable, goodwill, and other intangible assets.

Other assets are as follows as of December 31:

	2017	2016
Investment in nonconsolidated joint ventures	$ 315	285
Intangible assets	248	260
Goodwill	190	158
Beneficial interest in noncontrolled foundations	160	146
Other	284	269
Total other assets	$ 1,197	1,118

(Continued)

(In millions of dollars)

Goodwill is recorded as the excess of cost over fair value of the acquired net assets. Indefinite-lived intangible assets are recorded at fair value using various methods depending on the nature of the intangible asset. Both goodwill and indefinite-lived intangible assets are tested at least annually for impairment. Definite-lived intangible assets are amortized using the straight-line method over the estimated useful lives of the assets.

The Health System recorded goodwill impairment of $14 and $36 during the years ended December 31, 2017 and 2016, respectively attributable to medical group acquisitions made in previous years.

(j) Investments Including Assets Whose Use Is Limited

The Health System has classified all of its investments as trading securities. These investments are reported on the combined balance sheets at fair value on a trade-date basis.

Investment sales and purchases initiated prior to and settled subsequent to the combined balance sheet date result in amounts due from and to brokers. As of December 31, 2017, the Health System recorded a receivable of $174 for investments sold but not settled and a payable of $428 for investments purchased but not settled in other current assets and other current liabilities, respectively, in the accompanying combined balance sheets. As of December 31, 2016, the Health System recorded a receivable of $136 for investments sold but not settled and a payable of $375 for investments purchased but not settled in other current assets and other current liabilities, respectively, in the accompanying combined balance sheets.

Assets whose use is limited primarily include assets held by trustees under indenture agreements, self-insurance funds, funds held for the payment of health plan medical claims and other statutory reserve requirements, assets held by related foundations, and designated assets set aside by management of the Health System for future capital improvements and other purposes, over which management retains control.

Investment income from investments including assets whose use is limited are included in net nonoperating gains (losses) and are comprised of the following for the years ended December 31:

		2017	2016
Interest and dividend income	$	121	87
Net realized gains (losses) on sale of trading securities		166	(9)
Change in net unrealized gains on trading securities		595	325
Investment income, net	$	882	403

(k) Derivative Instruments

The Health System uses derivative financial instruments (interest rate swaps) to manage its interest rate exposure and overall cost of borrowing. As of December 31, 2017 and 2016, the Health System had interest rate swap contracts with a total current notional amount totaling $467 and $480, respectively, with varying expiration dates.

(Continued)

(In millions of dollars)

Derivative financial instruments are recorded at fair value taking into consideration the Health System's and the counterparties' nonperformance risk. As of December 31, 2017 and 2016, the fair value of outstanding interest rate swaps was in a net liability position of $101 and $104, respectively, and is included in other liabilities in the accompanying combined balance sheets. As of December 31, 2017 and 2016, collateral posted in connection with the outstanding swap agreements was $6 and $5, respectively, and is included in other assets in the accompanying combined balance sheets.

The interest rate swap agreements do not meet the criteria for hedge accounting and all changes in the valuation are recognized as a component of net nonoperating gains (losses) in the accompanying combined statements of operations. Settlements related to these agreements are recognized as a component of interest, depreciation, and amortization expense in the accompanying combined statements of operations. For the years ended December 31, 2017 and 2016, the change in valuation was a gain of $4 and $52, respectively, and settlements recognized as a component of interest expense were $12 and $7, respectively.

The Health System also allows certain investment managers to use derivative financial instruments (futures and forward currency contracts) to manage interest rate risk related to the Health System's fixed-income holdings. The investment managers have executed master netting arrangements with the counterparties of the futures and forward currency purchase and sale contracts whereby the financial instruments held by the same counterparty are legally offset as the instruments are settled. The following table presents gross investment derivative assets and liabilities reported on a net basis at fair value included in assets whose use is limited in the combined balance sheets as of December 31:

		2017	2016
Derivative assets:			
Futures contracts	$	275	394
Foreign currency forwards and other contracts		86	80
Total derivative assets	$	361	474
Derivative liabilities:			
Futures contracts	$	(275)	(394)
Foreign currency forwards and other contracts		(84)	(76)
Total derivative liabilities	$	(359)	(470)

(l) Self-Insurance Liabilities

The Health System has established self-insurance programs for professional and general liability and workers' compensation insurance coverage. These programs provide insurance coverage for healthcare institutions associated with the Health System. The Health System also operates insurance captives, Providence Assurance, Inc. and American Unity Group, Ltd., to self-insure or reinsure certain layers of professional and general liability risk.

(Continued)

(In millions of dollars)

The Health System accrues estimated self-insured professional and general liability and workers' compensation insurance claims based on management's estimate of the ultimate costs for both reported claims and actuarially determined estimates of claims incurred but not reported. Insurance coverage in excess of the per occurrence self-insured retention has been secured with insurers or reinsurers for specified amounts for professional, general, and workers' compensation liabilities. Decisions relating to the limit and scope of the self-insured layer and the amounts of excess insurance purchased are reviewed each year, subject to management's analysis of actuarial loss projections and the price and availability of acceptable commercial insurance.

At December 31, 2017 and 2016, the estimated liability for future costs of professional and general liability claims was $357 and $302, respectively. At December 31, 2017 and 2016, the estimated workers' compensation obligation was $309 and $306, respectively, both are recorded in other current liabilities and other liabilities in the accompanying combined balance sheets.

(m) Net Assets

Unrestricted net assets are those that are not subject to donor-imposed stipulations. Amounts related to the Health System's noncontrolling interests in certain joint ventures are included in unrestricted net assets. Temporarily restricted net assets are those whose use by the Health System has been limited by donors to a specific time period and/or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Health System in perpetuity. Unless specifically stated by donors, gains and losses on permanently restricted net assets are recorded as temporarily restricted.

Temporarily restricted net assets are available for the following purposes as of December 31:

		2017	2016
Program support	$	657	570
Capital acquisition		168	144
Low-income housing and other		133	102
Total temporarily restricted net assets	$	958	816

(n) Donor-Restricted Gifts

Unconditional promises to give cash and other assets to the Health System are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the promise to give is no longer conditional. The gifts are reported as either temporarily or permanently restricted contributions if they are received with donor stipulations that limit the use of the donated assets. When the terms of a donor restriction are met, temporarily restricted net assets are reclassified as unrestricted net assets and reported as other operating revenues in the combined statements of operations or as net assets released from restriction for donations of capital in the combined statements of changes in net assets.

(Continued)

(In millions of dollars)

(o) Net Patient Service Revenues

The Health System has agreements with governmental and other third-party payors that provide for payments to the Health System at amounts different from established charges. Payment arrangements for major third-party payors may be based on prospectively determined rates, reimbursed cost, discounted charges, per diem payments, or other methods.

Net patient service revenues are reported at the estimated net realizable amounts due from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with governmental payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as appropriate. Adjustments from finalization of prior years' cost reports and other third-party settlement estimates resulted in an increase in net patient service revenues of $27 for the year ended December 31, 2017 and a decrease in net patient service revenues of $1 for the year ended December 31, 2016, respectively.

The composition of payors as a percentage of net patient service revenues are as follows for the years ended December 31:

	2017	2016
Commercial	50 %	49 %
Medicare	33	32
Medicaid	14	16
Self-pay and other	3	3
	100 %	100 %

Various states in which the Health System operates have instituted a provider tax on certain patient service revenues at qualifying hospitals to increase funding from other sources and obtain additional Federal funds to support increased payments to providers for Medicaid services. The taxes are included in purchased services, professional fees, and other expenses in the accompanying combined statements of operations and were $434 and $495 for the years ended December 31, 2017 and 2016, respectively. These programs resulted in enhanced payments from these states in the way of lump-sum payments and per claim increases. These enhanced payments are included in net patient service revenues in the accompanying combined statements of operations and were $471 and $616 for the years ended December 31, 2017 and 2016, respectively.

(p) Allowance for Bad Debts

The Health System provides for an allowance against patient accounts receivable for amounts that could become uncollectible. The Health System estimates 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

(In millions of dollars)

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.

The estimates made and changes affecting those estimates are summarized as follows for the years ended December 31:

		2017	2016
Changes in allowance for bad debts:			
Allowance for doubtful accounts at beginning of year	$	271	344
Write-off of uncollectible accounts, net of recoveries		(313)	(276)
Provision for bad debts		269	203
Allowance for bad debts at end of year	$	227	271

(q) Charity Care and Community Benefit

The Health System provides community benefit activities that address significant health priorities within its geographic service areas. These activities include Medicaid and Medicare shortfalls, community health services, education and research, and free and low-cost care (charity care).

Charity care is reported at cost and is determined by multiplying the charges incurred at established rates for services rendered by the Health System's cost-to-charge ratio. The cost of charity care provided by the Health System for the years ended December 31, 2017 and 2016 was $259 and $174, respectively.

(r) Premium and Capitation Revenues

Premium and capitation revenues are received on a prepaid basis and are recognized as revenue during the month for which the enrolled member is entitled to healthcare services. Premium and capitation revenues received for future months are recorded as unearned premiums.

(s) Functional Expenses

The Health System provides healthcare services to residents within its geographic service areas. Expenses related to providing these services are as follows for the years ended December 31:

		2017	2016
Healthcare expenses	$	16,983	14,300
Purchased healthcare expenses		2,539	1,917
General and administrative expenses		3,638	2,911
Total operating expenses	$	23,160	19,128

(Continued)

(t) Subsequent Events

In February 2018, the Health System issued $350 of Series 2018A taxable bonds and $142 of Series 2018B Washington Health Care Facilities Authority revenue bonds.

The Health System has performed an evaluation of subsequent events through March 7, 2018, the date the accompanying combined financial statements were issued.

(u) New Accounting Pronouncements

In March 2017, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2017-07, *Compensation – Retirement Benefits (Topic 715): Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost.* The Health System adopted the ASU for the period beginning January 1, 2017, and $38 in net periodic benefit costs were recorded in net nonoperating gains (losses) on the statements of operations for the period ended December 31, 2017.

In January 2016, the FASB issued ASU 2016-01, *Financial Instruments – Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities*, which updates certain aspects of recognition, measurement, presentation and disclosure of financial instruments. The Health System has evaluated the impact and will be implementing ASU 2016-01 for the fiscal year beginning January 1, 2018.

In May 2014, the FASB issued ASU 2014-09, *Revenue from Contracts with Customers (Topic 606)*, to clarify the principles for recognizing revenue and to improve financial reporting by creating common revenue recognition guidance for U.S. generally accepted accounting principles and International Financial Reporting Standards. The amendments in the ASU can be applied either retrospectively to each prior reporting period presented or retrospectively with the cumulative effect of initially applying the update recognized at the date of the initial application along with additional disclosures. The Health System evaluated the impact of ASU 2014-09 and is implementing this ASU beginning January 1, 2018. Management will include new disclosures in 2018, in accordance with Topic 606. The adoption of Topic 606 will not have a significant impact on the Health System's results of operations.

In February 2016, the FASB issued ASU 2016-02, *Leases*, which requires lessees to recognize a lease liability and a right of use asset for all lease obligations with exception to short-term leases. The lease liability will represent the lessee's obligation to make lease payments arising from the lease measured on a discounted basis and the right of use asset will represent the lessee's right to use or control the use of a specified asset for a lease term. The lease guidance also simplifies accounting for sale-leaseback transactions. Because of the number of leases the Health System utilizes to support its operations, the adoption of ASU 2016-02 is expected to have a significant impact on the Health System's combined financial position and results of operations. The Health System is currently evaluating the extent of the anticipated impact of the adoption of ASU 2016-02, which is effective for the fiscal year beginning on January 1, 2019 with modified retrospective application to the earliest presented period.

(Continued)

In August 2016, the FASB issued ASU 2016-14, *Presentation of Financial Statements of Not-for-Profit Entities*, with the intent of reducing diversity in reporting practice, reduce complexity, and enhance understandability of not-for-profit (NFP) financial statements. This ASU contains the following key aspects; (A) Reduces the number of net asset classes presented from three to two: with donor restrictions and without donor restrictions; (B) Requires all NFPs to present expenses by their functional and their natural classifications in one location in the financial statements; (C) Requires NFPs to provide quantitative and qualitative information about management of liquid resources and availability of financial assets to meet cash needs within one year of the balance sheet date; and (D) Retains the options to present operating cash flows in the statement of cash flows using either the direct or indirect method. The Health System has evaluated the impact of ASU 2016-14 and will be implementing this ASU for the fiscal year beginning January 1, 2018. The impact of adoption will result in enhanced disclosures about the classification of expenses and management of liquid resources.

(v) Reclassifications

Certain reclassifications, which have no impact on net assets or changes in net assets, have been made to prior year amounts to conform to the current year presentation.

(2) Affiliated Activities and Divestitures

Effective February 23, 2017 the Health System and Catholic Health Initiatives entered into an agreement with Laboratory Corporation of America to sell all of its ownership interest in Pathology Associates Medical Laboratories (PAML) and its affiliated joint ventures. PAML was a PHS consolidated joint venture. A gain in the amount of $133 was recorded in other operating revenues on the combined statements of operations during the year ended December 31, 2017.

On July 1, 2016, PHS and SJHS entered into a business combination agreement, the purpose of which was to better serve both organizations' communities, maintain strong traditions of Catholic healthcare, and provide greater affordability and access to healthcare services. As part of the business combination, PHS and SJHS aligned under a single parent corporation, Providence St. Joseph Health, with a consolidated board of directors and cosponsorship from the public juridic persons Providence Ministries and St. Joseph Health Ministry.

SJHS provides a full range of care facilities including 16 acute care hospitals, home health agencies, hospice care, outpatient services, skilled nursing facilities, community clinics, and physician groups spanning California, west Texas, and eastern New Mexico. The results of operations of these entities have been included in the combined statements of operations of the Health System since July 1, 2016, the effective date of the business combination.

The transition was accounted for as an acquisition under Accounting Standards Codification (ASC) 958-805, *Not-for-Profit Entities – Business Combinations*. The affiliation did not involve consideration and resulted in an excess of assets acquired over liabilities assumed, reported as a contribution of net assets from SJHS to the Health System of approximately $5,644. The unrestricted portion of the contribution of $5,163 is included in net nonoperating gains in the accompanying combined statement of operations for the year ended December 31, 2016. The remaining $481 of the contribution was restricted and is recorded in restricted net assets in the combined statement of changes in net assets for the year ended December 31, 2016.

(In millions of dollars)

The following table summarizes the fair value estimate of the SJHS assets acquired and liabilities assumed as of July 1, 2016:

Cash and cash equivalents	$	359
Accounts receivable, net		607
Supplies inventory		66
Other current assets		290
Assets whose use is limited		3,372
Property, plant, and equipment, net		4,388
Other assets		555
Accounts payable		(146)
Accrued compensation		(344)
Other current liabilities		(569)
Long-term debt		(2,486)
Other liabilities		(448)
Total contribution of net assets	$	5,644

The following are the financial results of SJHS included in the Health System's 2016 combined statement of operations during the six-month period from the date of the affiliation through December 31, 2016:

Total operating revenues	$	3,520
Excess of revenue over expenses from operations		46
Excess of revenues over expenses		130

The following unaudited pro forma combined financial information presents the Health System's results as if the affiliation had been reported as of the beginning of the Health System's fiscal year of January 1, 2016:

	2016		
	Actual	**Pro forma** (Unaudited)	
Total operating revenues	$ 18,879	22,157	(1)
Deficit of revenues over expenses from operations	(249)	(265)	(1)(2)
Excess of revenues over expenses	5,231	57	(1)

(1) Includes the historical results of SJHS for the six-month period ended June 30, 2016 prior to the affiliation, including the impact of purchase accounting adjustments.

(2) Includes additional depreciation related to the fair value adjustments and useful life adjustments recorded related to the affiliation.

(Continued)

Effective April 1, 2016, the Health System entered into a business combination agreement with the Institute for Systems Biology (ISB). The transaction was accounted for as an acquisition under ASC 958-805. The affiliation resulted in an excess of assets acquired over liabilities assumed, reported as a contribution from ISB to the Health System of approximately $19. The unrestricted portion of the contribution of $4 is included in net nonoperating gains in the accompanying combined statement of operations for the year ended December 31, 2016. The remaining $15 of the contribution was restricted and is recorded in restricted net assets in the combined statement of changes in net assets for year ended December 31, 2016.

(3) Fair Value Measurements

ASC Topic 820 (Topic 820), *Fair Value Measurements*, requires a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 inputs include quoted prices (unadjusted) in active markets for identical assets or liabilities that the Health System has the ability to access at the measurement date.
- Level 2 inputs include inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly.
- Level 3 inputs are unobservable inputs for the asset or liability.

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

(a) Assets Whose Use Is Limited

The fair value of assets whose use is limited, other than those investments measured using NAV as a practical expedient for fair value, is estimated using quoted market prices or other observable inputs when quoted market prices are unavailable.

(Continued)

(In millions of dollars)

The composition of assets whose use is limited is set forth in the following tables:

	December 31, 2017	Fair value measurements at reporting date using		
		Level 1	Level 2	Level 3
Management-designated cash and investments:				
Cash and cash equivalents	$ 547	547	—	—
Equity securities:				
Domestic	1,058	1,058	—	—
Foreign	372	372	—	—
Mutual funds	1,313	1,313	—	—
Domestic debt securities:				
State and federal government	1,441	961	480	—
Corporate	717	—	717	—
Other	460	—	460	—
Foreign debt securities	155	—	155	—
Commingled funds	545	545	—	—
Other	20	—	20	—
Investments measured using NAV	3,312			
Total management-designated cash and investments	9,940			
Gift annuities, trusts, and other	181	41	35	105
Funds held by trustee:				
Cash and cash equivalents	105	105	—	—
Domestic debt securities	216	113	103	—
Foreign debt securities	24	—	24	—
Total funds held by trustee	345			
Total assets whose use is limited	$ 10,466			

(Continued)

(In millions of dollars)

	December 31, 2016	Fair value measurements at reporting date using Level 1	Level 2	Level 3
Management-designated cash and investments:				
Cash and cash equivalents	$ 572	572	—	—
Equity securities:				
Domestic	1,000	1,000	—	—
Foreign	280	280	—	—
Mutual funds	828	828	—	—
Domestic debt securities:				
State and federal government	1,518	1,011	507	—
Corporate	766	—	766	—
Other	503	—	503	—
Foreign debt securities	172	—	172	—
Commingled funds	575	575	—	—
Other	32	20	12	—
Investments measured using NAV	2,752			
Total management-designated cash and investments	8,998			
Gift annuities, trusts, and other	131	32	11	88
Funds held by trustee:				
Cash and cash equivalents	147	147	—	—
Domestic debt securities	198	68	130	—
Foreign debt securities	23	—	23	—
Total funds held by trustee	368			
Total assets whose use is limited	$ 9,497			

The Health System participates in various funds that are not actively marketed on an open exchange. These investments consist of shares or units in investment funds as opposed to direct interests in the funds' underlying holdings, which may be marketable. Due to the nature of these funds the NAV per share, or its equivalent, reported by each fund manager is used as a practical expedient to estimate the fair value of the Health System's interest therein. Management believes that the carrying amounts of these financial instruments, provided by the fund managers, are reasonable estimates of fair value.

(Continued)

(In millions of dollars)

The following table presents information, including unfunded commitments as of December 31, 2017, for investments where the NAV was used to estimate the value of the investments as of December 31:

	Fair value		Unfunded commitments	Redemption frequency	Redemption notice period
	2017	2016			
Hedge funds:					
Long/short equity	$ 579	501	—	Monthly, quarterly, semi-annually, or annually	30–120 days
Credit	300	166	—	Quarterly or annually	45–150 days
Relative value	206	194	—	Quarterly	60–90 days
Global macros	278	226	—	Monthly or quarterly	2–90 days
Fund of hedge funds	82	80	—	Quarterly	90 days
Private equity	258	214	350	Not applicable	Not applicable
Private real estate	75	33	159	Not applicable	Not applicable
Risk parity	110	173	—	Monthly or annually	5–60 days
Real assets	315	327	60	Monthly or quarterly	10–60 days
Commingled	1,109	838	—	Monthly, quarterly, or semi-annually	6–90 days
Total	$ 3,312	2,752	569		

The following is a summary of the nature of these investments and their associated risks:

Hedge funds are portfolios of investments that use advanced investment strategies, such as long/short equity, credit, relative value, global macro, and fund of hedge funds positions in both domestic and international markets, with the goal of diversifying portfolio risk and generating return. The Health System's investments in hedge funds include certain funds with provisions that limit the Health System's ability to access assets invested. These provisions include lockup terms that range up to three years from the subscription date or are continuous and determined as a percent of total assets invested. The Health System is in various stages of the lockup periods dependent on hedge fund and period of initial investments.

Private equity and private real estate funds make opportunistic investments that are primarily private in nature. These investments cannot be redeemed by the Health System; rather the Health System has committed an amount to invest in the private funds over the respective commitment periods. After the commitment period has ended, the nature of the investments in this category is that the distributions are received through the liquidation of the underlying assets.

Risk parity is an approach to investment portfolio management which focuses on allocation of risk, usually defined as volatility, rather than allocation of capital. The risk parity approach asserts that when asset allocations are adjusted to the same risk level, the risk parity portfolio can achieve a higher Sharpe ratio and can be more resistant to market downturns than the traditional portfolio. The key to risk parity is to diversify across asset classes that behave differently across economic environments.

Real asset strategies invest in securities backed by tangible real assets, with the objective of achieving attractive diversified total returns over the long term, while maximizing the potential for real returns in

(In millions of dollars)

periods of rising inflation. Real asset investments should provide a return in excess of inflation, and their performance should be sensitive to changes in inflation or expectations for future levels of inflation. The real asset category is made up of many different underlying sectors inclusive of agriculture, commodities, gold, infrastructure, private energy, MLPs (Master Limited Partnerships), real estate, REITs (Real Estate Investment Trusts), timberland, and TIPS (Treasury Inflation Protected Securities). Each of these sectors tends to have a high degree of sensitivity to inflation and be less correlated with traditional equities and fixed income.

Commingled describes a type of fund structure. Commingled funds consist of assets from several accounts that are blended together. Investors in commingled fund investments benefit from economies of scale, which allow for lower trading costs per dollar of investment.

(b) Derivative Instruments

The fair value of the interest rate swaps is based on independent valuations obtained and are determined by calculating the value of the discounted cash flows of the differences between the fixed interest rate of the interest rate swaps and the counterparty's forward London Interbank Offered Rate curve, which is the input used in the valuation, taking also into account any nonperformance risk. Collateral posted for the interest rate swaps consist of cash and U.S. government securities, which are both categorized as Level 1 financial instruments.

The following tables present the fair value of swaps and related collateral:

	December 31, 2017	Fair value measurements at reporting date using		
		Level 1	Level 2	Level 3
Cash collateral held by swap counterparty	$ 6	6	—	—
Liabilities under interest rate swaps	101	—	101	—

	December 31, 2016	Fair value measurements at reporting date using		
		Level 1	Level 2	Level 3
Cash collateral held by swap counterparty	$ 5	5	—	—
Liabilities under interest rate swaps	104	—	104	—

(c) Debt

The fair value of long-term debt is based on Level 2 inputs, such as the discounted value of the future cash flows using current rates for debt with the same remaining maturities, considering the existing call premium and protection. The carrying value and fair value of long-term debt was $6,620 and $6,963, respectively, as of December 31, 2017, and $6,749 and $6,980, respectively, as of December 31, 2016.

(In millions of dollars)

(d) Assets Measured Using Significant Unobservable Inputs

The following table presents the Health System's activity for assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) as defined in Topic 820:

Balance at December 31, 2015	$	62
Level 3 assets acquired through affiliation		8
Total realized and unrealized gains, net		1
Total purchases		16
Total sales		(3)
Transfers into Level 3		4
Balance at December 31, 2016		88
Total realized and unrealized losses, net		(2)
Total purchases		21
Total sales		(2)
Balance at December 31, 2017	$	105

There were no significant transfers between assets classified as Level 1 and Level 2 during the years ended December 31, 2017 and 2016.

Level 3 assets include charitable remainder trusts, real property, and equity investments in healthcare technology start-ups through the Health System's innovation venture capital fund. Fair values of real property were estimated using a market approach. Fair values of charitable remainder trusts were estimated using an income approach. Fair value of equity investments in healthcare technology start-ups were estimated using a combination of income and market approach.

(4) Debt

(a) Short-Term and Long-Term Debt

The Health System has borrowed master trust debt issued through the following:

- California Health Facilities Financing Authority (CHFFA)
- Alaska Industrial Development and Export Authority (AIDEA)
- Washington Health Care Facilities Authority (WHCFA)
- Montana Facility Finance Authority (MFFA)
- Lubbock Health Facilities Development Corp (LHFDC)
- Oregon Facilities Authority (OFA)

(Continued)

(In millions of dollars)

Short-term and long-term unpaid principal at December 31 consists of the following:

	Maturing through	Coupon rates	Unpaid principal 2017	Unpaid principal 2016
Master trust debt:				
Fixed rate:				
Series 1997, Direct Obligation Notes	2017	7.70%	$ —	1
Series 2005, Direct Obligation Notes	2030	4.31–5.39%	40	42
Series 2006C, WHCFA Revenue Bonds	2033	5.25%	69	69
Series 2006D, WHCFA Revenue Bonds	2033	5.25%	69	69
Series 2006E, WHCFA Revenue Bonds	2033	5.25%	26	26
Series 2008B, LHFDC Revenue Bonds	2023	4.00–5.00%	33	46
Series 2008C, CHFFA Revenue Bonds	2038	3.00–6.50%	6	12
Series 2009A, Direct Obligation Notes	2019	5.05–6.25%	100	100
Series 2009A, CHFFA Revenue Bonds	2039	5.50–5.75%	185	185
Series 2009B, CHFFA Revenue Bonds	2039	5.50%	150	150
Series 2009B, CHFFA Revenue Bonds	2021	3.00–5.25%	37	42
Series 2009C, CHFFA Revenue Bonds	2034	5.00%	91	91
Series 2009D, CHFFA Revenue Bonds	2034	1.70%	40	40
Series 2010A, WHCFA Revenue Bonds	2039	4.88–5.25%	174	174
Series 2011A, AIDEA Revenue Bonds	2041	5.00–5.50%	123	123
Series 2011B, WHCFA Revenue Bonds	2021	2.00–5.00%	42	51
Series 2011C, OFA Revenue Bonds	2026	3.50–5.00%	15	17
Series 2012A, WHCFA Revenue Bonds	2042	2.00–5.00%	480	489
Series 2012B, WHCFA Revenue Bonds	2042	4.00–5.00%	100	100
Series 2013A, OFA Revenue Bonds	2024	2.00–5.00%	54	61
Series 2013A, CHFFA Revenue Bonds	2037	4.00–5.00%	325	325
Series 2013B, CHFFA Revenue Bonds	2043	4.15–4.26%	—	110
Series 2013C, CHFFA Revenue Bonds	2043	4.15–4.26%	110	110
Series 2013D, Direct Obligation Notes	2023	4.38%	252	252
Series 2013D, CHFFA Revenue Bonds	2043	4.15–4.26%	110	110
Series 2014A, CHFFA Revenue Bonds	2038	2.00–5.00%	270	273
Series 2014B, CHFFA Revenue Bonds	2044	4.25–5.00%	119	119
Series 2014C, WHCFA Revenue Bonds	2044	4.00–5.00%	92	92
Series 2014D, WHCFA Revenue Bonds	2041	5.00%	179	179
Series 2015A, WHCFA Revenue Bonds	2045	4.00%	78	78
Series 2015C, OFA Revenue Bonds	2045	4.00–5.00%	71	71
Series 2016A, CHFFA Revenue Bonds	2047	2.50–5.00%	448	448
Series 2016B, CHFFA Revenue Bonds	2036	1.25–4.00%	286	286
Series 2016H, Direct Obligation Bonds	2036	2.75%	300	300
Series 2016I, Direct Obligation Bonds	2047	3.74%	400	400
Total fixed rate			4,874	5,041

(Continued)

(In millions of dollars)

	Maturing through	Effective interest rate (1) 2017	Effective interest rate (1) 2016	Unpaid principal 2017	Unpaid principal 2016
Variable rate:					
Series 2012C, WHCFA Revenue Bonds	2042	0.86 %	0.43 %	80	80
Series 2012D, WHCFA Revenue Bonds	2042	0.86	0.43	80	80
Series 2012E, Direct Obligation Notes	2042	1.08	0.57	229	231
Series 2013C, OFA Revenue Bonds	2022	1.79	1.41	57	117
Series 2013E, Direct Obligation Notes	2017	6.28	4.79	—	100
Series 2016C, LHFDC Revenue Bonds	2030	0.86	0.24	37	39
Series 2016D, WHCFA Revenue Bonds	2036	1.34	1.04	106	106
Series 2016E, WHCFA Revenue Bonds	2036	1.26	0.96	106	106
Series 2016F, MFFA Revenue Bonds	2026	1.23	0.93	46	50
Series 2016G, Direct Obligation Notes	2047	1.08	0.76	100	100
Total variable rate				841	1,009
Wells Fargo Credit Facility	2019	1.73	—	110	—
Wells Fargo Credit Facility	2021	1.63	1.22	369	252
Unpaid principal, master trust debt				6,194	6,302
Premiums, discounts, and unamortized financing costs, net				148	167
Master trust debt, including premiums and discounts, net				6,342	6,469
Other long-term debt				278	280
Total debt				$ 6,620	6,749

(1) Variable rate debt and credit facilites carry floating interest rates attached to indexes, which are subject to change based on market conditions.

In November 2017, the Health System received a Well Fargo Bridge Loan for $110 and repaid the CHFFA Series 2013B revenue bonds.

In September and November 2016, the Health System issued $1,835 Series 2016A through 2016I revenue bonds and direct obligation notes. The intended uses of funds included refinancing legacy SJHS and PHS master trust debt and repayment of outstanding lines of credit and commercial paper. Certain issues within the 2016 series debt included remarketing provisions for which the Health System purchased supporting credit facilities that allow the Health System to treat the obligations as noncurrent though remarketing may occur within less than one year.

In connection with the Series 2016A-I issuance, the Health System recorded losses due to extinguishment of debt of $60 in the year ended December 31, 2016, which was recorded in net nonoperating gains (losses) in the accompanying combined statement of operations.

(Continued)

(In millions of dollars)

The following table reflects classification of long-term debt obligations in the accompanying combined balance sheets as of December 31:

	2017	2016
Current portion of long-term debt	$ 78	200
Short-term master trust debt	57	153
Long-term debt, classified as a long-term liability	6,485	6,396
Total debt	$ 6,620	6,749

Short-term master trust debt represents debt issues with remarketing provisions unsupported by credit facilities with mandatory redemption within one year of the December 31, 2017 and 2016.

(b) Other Long-Term Debt

Other long-term debt primarily includes capital leases, notes payable, and bonds that are not under the master trust indenture. Other long-term debt at December 31 consists of the following:

	2017	2016
Capital leases	$ 152	159
Notes payable	105	110
Bonds not under master trust indenture and other	21	11
Total other long-term debt	$ 278	280

(c) Debt Service

Scheduled principal payments of long-term debt, considering all obligations under the master trust indenture as due according to their long-term amortization schedule, for the next five years and thereafter are as follows:

	Master trust	Other	Total
2018	$ 69	9	78
2019	283	11	294
2020	93	11	104
2021	472	10	482
2022	107	10	117
Thereafter	5,170	227	5,397
Scheduled principal payments of long-term debt	$ 6,194	278	6,472

(Continued)

(In millions of dollars)

(5) Retirement Plans

(a) Defined Benefit Plans

The Health System sponsors various frozen defined benefit retirement plans. The measurement dates for the defined benefit plans are December 31. A rollforward of the change in projected benefit obligation and change in the fair value of plan assets for the defined benefit plans is as follows:

		2017	2016
Change in projected benefit obligation:			
Projected benefit obligation at beginning of year	$	2,680	2,600
Service cost		23	22
Interest cost		114	94
Actuarial loss		110	140
Benefits paid and other		(186)	(176)
Projected benefit obligation at end of year		2,741	2,680
Change in fair value of plan assets:			
Fair value of plan assets at beginning of year		1,559	1,535
Actual return on plan assets		218	119
Employer contributions		95	81
Benefits paid and other		(186)	(176)
Fair value of plan assets at end of year		1,686	1,559
Funded status		(1,055)	(1,121)
Unrecognized net actuarial loss		495	552
Unrecognized prior service cost		3	4
Net amount recognized	$	(557)	(565)
Amounts recognized in the combined balance sheets consist of:			
Current liabilities	$	(1)	(1)
Noncurrent liabilities		(1,054)	(1,120)
Unrestricted net assets		498	556
Net amount recognized	$	(557)	(565)
Weighted average assumptions:			
Discount rate		4.00 %	4.40 %
Rate of increase in compensation levels		3.50	3.50
Long-term rate of return on assets		6.50	6.90

(Continued)

(In millions of dollars)

Net periodic pension cost for the defined benefit plans includes the following components:

	2017	2016
Components of net periodic pension cost:		
Service cost	$ 23	22
Interest cost	114	94
Expected return on plan assets	(102)	(107)
Amortization of prior service cost	1	1
Recognized net actuarial loss	25	19
Net periodic pension cost	$ 61	29
Special recognition – settlement expense	$ 25	28

Certain plans sponsored by the Health System allow participants to receive their benefit through a lump-sum distribution upon election. When lump-sum distributions exceed the combined total of service cost and interest cost during a reporting period settlement expense is recognized. Settlement expense represents the proportional recognition of unrecognized actuarial loss and prior service cost. Settlement expense for the years ended December 31, 2017 and 2016 is included in net nonoperating gains (losses) in the accompanying combined statements of operations.

The accumulated benefit obligation was $2,672 and $2,628 at December 31, 2017 and 2016, respectively.

The following pension benefit payments reflect expected future service. Payments expected to be paid over the next 10 years are as follows:

2018	$ 178
2019	185
2020	191
2021	195
2022–2027	1,077
	$ 1,826

The Health System expects to contribute approximately $96 to the defined benefit plans in 2018.

The expected long-term rate of return on plan assets is the expected average rate of return on the funds invested currently and on funds to be invested in the future in order to provide for the benefits included in the projected benefit obligation. The Health System used 6.5% and 6.9% in calculating the 2017 and 2016 expense amounts, respectively. This assumption is based on capital market assumptions and the plan's target asset allocation.

(Continued)

(In millions of dollars)

The Health System continues to monitor the expected long-term rate of return. If changes in those parameters cause 6.5% to be outside of a reasonable range of expected returns, or if actual plan returns over an extended period of time, suggest that general market assumptions are not representative of expected plan results, the Health System may revise this estimate prospectively.

The target asset allocation and expected long-term rate of return on assets (ELTRA) as of December 31, 2017 and 2016, respectively, were as follows:

	2017 Target	2017 ELTRA	2016 Target	2016 ELTRA
Cash and cash equivalents	2 %	2%–3%	1 %	1%–3%
Equity securities	45	7%–8%	42	5%–9%
Debt securities	33	3%–4%	35	2%–5%
Other securities	20	5%–8%	22	5%–9%
Total	100 %	6.5 %	100 %	6.9 %

The following table presents the Health System's defined benefit plan assets measured at fair value:

	December 31, 2017	Fair value measurements at reporting date using Level 1	Level 2	Level 3
Assets:				
Cash and cash equivalents	$ 68	68	—	—
Equity securities:				
Domestic	177	177	—	—
Foreign	48	48	—	—
Mutual funds	127	127	—	—
Domestic debt securities:				
State and government	272	210	62	—
Corporate	129	—	129	—
Other	13	—	13	—
Foreign debt securities	30	—	30	—
Commingled funds	170	170	—	—
Investments measured using NAV	720			
Transactions pending settlement, net	(68)			
Total	$ 1,686			

(Continued)

(In millions of dollars)

The following table presents the Health System's defined benefit plan assets measured at fair value:

	December 31, 2016	Fair value measurements at reporting date using Level 1	Level 2	Level 3
Assets:				
Cash and cash equivalents	$ 58	58	—	—
Equity securities:				
Domestic	192	192	—	—
Foreign	37	37	—	—
Mutual funds	104	104	—	—
Domestic debt securities:				
State and government	251	173	78	—
Corporate	115	—	115	—
Other	15	—	15	—
Foreign debt securities	30	—	30	—
Commingled funds	157	157	—	—
Investments measured using NAV	663			
Transactions pending settlement, net	(63)			
Total	$ 1,559			

The Health System's defined benefit plans participate in various funds that are not actively marketed on an open exchange. These investments consist of shares or units in investment funds as opposed to direct interests in the funds' underlying holdings, which may be marketable. Due to the nature of these funds the NAV per share, or its equivalent, reported by each fund manager is used as a practical expedient to estimate the fair value of the Health System's interest therein. Management believes that the carrying amounts of these financial instruments provided by the fund managers are reasonable estimates of fair value.

The following table presents information for investments where either the NAV per share or its equivalent was used to value the investments as of December 31:

	Fair value 2017	Fair value 2016	Redemption frequency	Redemption notice period
Hedge funds:				
Long/short equity	$ 52	74	Monthly or quarterly	30–65 days
Credit and other	56	52	Monthly or quarterly	90 days
Real assets	92	116	Monthly	30 days
Risk parity	130	111	Monthly	5–15 days
Commingled	390	310	Monthly	6–30 days
Total	$ 720	663		

(Continued)

(In millions of dollars)

The Health System's defined benefit plans also allow certain investment managers to use derivative financial instruments (futures and forward currency contracts) to manage interest rate risk related to the plans' fixed-income holdings. The investment managers have executed master netting arrangements with the counterparties of the futures and forward currency purchase and sale contracts whereby the financial instruments held by the same counterparty are legally offset as the instruments are settled. The following table presents gross investment derivative assets and liabilities reported on a net basis at fair value included in the plans' assets as of December 31:

		2017	2016
Derivative assets:			
Futures contracts	$	926	16
Foreign currency forwards and other contracts		5	7
Total derivative assets	$	931	23
Derivative liabilities:			
Futures contracts	$	(926)	(16)
Foreign currency forwards and other contracts		(4)	(5)
Total derivative liabilities	$	(930)	(21)

(b) Defined Contribution Plans

The Health System sponsors various defined contribution retirement plans that cover substantially all employees. The plans provide for employer matching contributions in an amount equal to a percentage of employee pretax contributions, up to a maximum amount. In addition, the Health System makes contributions to eligible employees based on years of service. Retirement expense related to these plans was $478 and $440 in 2017 and 2016, respectively, and is reflected in salaries and benefit expense in the accompanying combined statements of operations.

(6) Commitments and Contingencies

(a) Commitments

Firm purchase commitments, primarily related to construction and equipment and software acquisition, at December 31, 2017 are approximately $381.

(b) Operating Leases

The Health System leases various medical and office equipment and buildings under operating leases.

(Continued)

(In millions of dollars)

Future minimum lease commitments under noncancelable operating leases for the next five years and thereafter are as follows:

2018	$	221
2019		204
2020		186
2021		165
2022		144
Thereafter		773
	$	1,693

Rental expense, including month-to-month leases and contingent rents, was $382 and $302 for the years ended December 31, 2017 and 2016, respectively, and is included in other expenses in the accompanying combined statements of operations.

(c) Litigation

The healthcare industry is subject to numerous laws and regulations from federal, state, and local governments. Compliance with these laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time. Government monitoring and enforcement activity continues with respect to investigations and allegations concerning possible violations by healthcare providers of regulations, which could result in the imposition of significant fines and penalties, as well as significant repayments of patient services previously billed. Institutions within the Health System are subject to similar regulatory reviews.

Management is aware of certain asserted and unasserted legal claims and regulatory matters arising in the course of business. After consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on the Health System's combined financial statements.

PROVIDENCE ST. JOSEPH HEALTH

Supplemental Schedule - Obligated Group Combining Balance Sheets Information

December 31, 2017 and 2016

(In millions of dollars)

	2017			2016		
Assets	**Obligated Group**	**Non Obligated, Eliminations, Other**	**Total Combined**	**Obligated Group**	**Non Obligated, Eliminations, Other**	**Total Combined**
Current assets:						
Cash and cash equivalents	$ 787	584	1,371	551	449	1,000
Accounts receivable, net	2,148	74	2,222	2,123	83	2,206
Supplies inventory	270	7	277	266	13	279
Other current assets	1,103	54	1,157	1,378	(209)	1,169
Current portion of assets whose use is limited	256	224	480	492	274	766
Total current assets	4,564	943	5,507	4,810	610	5,420
Assets whose use is limited	7,580	2,406	9,986	6,820	1,911	8,731
Property, plant, and equipment, net	10,496	459	10,955	10,561	461	11,022
Other assets	1,732	(535)	1,197	1,594	(476)	1,118
Total assets	$ 24,372	3,273	27,645	23,785	2,506	26,291
Liabilities and Net Assets						
Current liabilities:						
Current portion of long-term debt	$ 76	2	78	194	6	200
Master trust debt classified as short-term	57	—	57	153	—	153
Accounts payable	624	60	684	506	126	632
Accrued compensation	1,033	78	1,111	1,026	78	1,104
Other current liabilities	1,623	668	2,291	1,289	574	1,863
Total current liabilities	3,413	808	4,221	3,168	784	3,952
Long-term debt, net of current portion	6,457	28	6,485	6,377	19	6,396
Pension benefit obligation	1,054	—	1,054	1,120	—	1,120
Other liabilities	509	630	1,139	535	492	1,027
Total liabilities	11,433	1,466	12,899	11,200	1,295	12,495
Net assets:						
Unrestricted	12,178	1,367	13,545	11,921	839	12,760
Temporarily restricted	622	336	958	535	281	816
Permanently restricted	139	104	243	129	91	220
Total net assets	12,939	1,807	14,746	12,585	1,211	13,796
Total liabilities and net assets	$ 24,372	3,273	27,645	23,785	2,506	26,291

See accompanying independent auditors' report

PROVIDENCE ST. JOSEPH HEALTH

Supplemental Schedule – Obligated Group Combining Statements of Operations Information

Years ended December 31, 2017 and 2016

(In millions of dollars)

	2017			2016		
	Obligated Group	Non Obligated, Eliminations, Other	Total Combined	Obligated Group	Non Obligated, Eliminations, Other	Total Combined
Operating revenues:						
Net patient service revenues	$ 17,630	506	18,136	13,615	1,357	14,972
Provision for bad debts	(243)	(26)	(269)	(150)	(53)	(203)
Net patient service revenues less provision for bad debts	17,387	480	17,867	13,465	1,304	14,769
Other revenues	1,844	3,452	5,296	1,147	2,963	4,110
Total operating revenues	19,231	3,932	23,163	14,612	4,267	18,879
Operating expenses:						
Salaries and benefits	10,391	1,073	11,464	8,199	1,400	9,599
Supplies	3,194	196	3,390	2,419	369	2,788
Interest, depreciation, and amortization	1,232	75	1,307	897	169	1,066
Purchased services, professional fees, and other	3,827	3,172	6,999	2,957	2,718	5,675
Total operating expenses	18,644	4,516	23,160	14,472	4,656	19,128
Excess (deficit) of revenues over expenses from operations	587	(584)	3	140	(389)	(249)
Net nonoperating gains (losses):						
Contributions from affiliations	—	—	—	—	5,167	5,167
Loss on extinguishment of debt	—	—	—	(60)	—	(60)
Investment income, net	773	109	882	277	126	403
Other	(4)	(101)	(105)	(12)	(18)	(30)
Total net nonoperating gains	769	8	777	205	5,275	5,480
Excess of revenues over expenses	$ 1,356	(576)	780	345	4,886	5,231

See accompanying independent auditors' report.

Exhibit 23
Kadlec Chief Medical Officer Job Description

Kadlec Regional Medical Center
Richland, Washington

Job Description

Title: VP MEDICAL AFFAIRS/CMO

Department: Administration

Job Code: 12030

Department #: 86100

Effective Date: January, 2016

Supersedes: December, 2014

Approved: President and CEO, Kadlec Regional Medical Center

Purpose of Position: The key element of the Vice President, Medical Affairs/CMO (VPMA) role is to provide counsel to the Executive Team regarding the Medical Staff's point of view on issues of medical affairs addressed by the Executive Team. In addition, it is the VPMA's responsibility to be a liaison from the Executive Team to the Medical Staff so that a smooth line of communication, coordination, and transparency while maintaining confidentiality is enhanced between the Executive Team and the Medical Staff. In addition, the role of the VPMA is central in the development of patient safety and in the maintenance and improvement of high quality, cost-effective services that meet the needs of patients, the Medical Staff, and community.

Qualifications:

Education: Board Certified Provider in area of specialty required.

Experience: Provider experience required.

Licensure/Credentials: Current licensure to practice in the State of Washington required.

Working Conditions:

Location of Work: Primary location is an office on the third floor of the Mountain Pavilion. Incumbent travels intermittently to other locations and business enterprises in city and other cities.

Equipment Used: Personal computers, copy machine, fax, dictation recorder, telephone, PDAs.

Physical Demands: Requires normal/corrected vision and hearing to normal range. Physical demand level is light; sits at desk with intermittent standing and walking. Requires automobile and air travel. This position is in a high stress situation working with varied objectives, multiple publics and managing numerous projects at the same time. Subject to long and irregular hours and many interruptions of daily work.

Exposure to Hazards: OSHA category 3.

Hours of Work: Shifts may vary depending on business needs.

Essential Functions:

1. Embraces Planetree Philosophy to provide a safe, comfortable, therapeutic, patient-centered environment.
2. **Quality and Safety**:
   a. Provides a leadership role in medical quality and safety development and implementation for KRMC by participating in the Medical Staff Quality Committee and the KRMC Board Quality Committee.

b. Coordinates with the Chair of the Medical Staff Quality Committee and the Director of Quality Care Management to determine quality and safety objectives and implementation for KRMC based on CMS requirements and nationally recognized standards. This includes the development and carrying out of quality improvement initiatives. This will also include interactions with patients, families, physicians, nurses, allied health personal, visitors, venders, volunteers, and community members all to promote the vision, mission and values of KRMC.

3. **Medical Staff**:
   a. Provides a leadership role with the Medical Staff participating in the Medical Executive Committee and coordinating with the Chief of Staff's in issues pertaining to the Medical Staff and health systems operations. This includes contact with the physician directors of the various departments and periodic attendance at Medical Staff Departmental meetings, and the Medical Staff Committees as indicated. This also includes leadership in physician peer review, credentialing, establishing and maintaining medical directors, medical staff development, and recruiting.
4. **Medical Advisor**:
   a. Functions as a medical advisor for case management, compliance, electronic medical records, infection control, utilization review, performance improvement, risk management, and other Medical Center functions as requested by the CEO.
5. **Physician Health**:
   a. Participates in the Physician Wellness Committee and provides leadership in advocating for physician health.
6. **Strategy Team**:
   a. Participates in the executive strategy team and in the various meetings and functions of the Executive Team.
7. **Management Councils and Boards**:
   a. Represents the executive team in the management councils for Kadlec Medical Associates, Kadlec Clinic, and Kadlec Neurosciences.
   b. Represents the executive team on the KRMC Board and KHS Board.
8. **Access for Physicians**:
   a. Maintains open accessibility to all physicians and acts as a central point of contact for them regarding issues of concern about medical affairs at KRMC.
9. **Liaison Between Physicians and KRMC Departments**:
   a. Functions as a liaison between hospital departments and physicians to enhance coordination and communication.
10. **Community Outreach**:
    a. Remains available for outreach projects to the community regarding community wide health education, and community projects undertaken by KRMC. This includes but is not limited to the Kadlec Neuroscience Resource Center.
11. **Lean Principles**:
    a. Knows and champions the lean principles related to clinical improvement efforts.
12. Performs other duties as assigned.

Knowledge, Skills, Abilities:

1. Working knowledge of the role of information and the use of information in a quality program.
2. Excellent management skills in order to provide leadership, achieve desired goals, and interact effectively with the Physician Groups; Health Plans; and Health Care Operations team members, business, and community leaders and representatives of local, state, and national bodies.
3. Strong communication and listening skills.
4. Ability to demonstrate experience in leadership.
5. Ability to demonstrate a high regard for quality, safety, and performance improvement.
6. Ability to maintain an executive presence.
7. Ability to be effective in accomplishing objectives in a complex organization, including conflict resolution.

Exhibit 24
Kevin Pieper, MD
Washington Department of Health Credential Details

DISCLAIMER: The absence or presence of information in this system does not imply any recommendation, endorsement, or guarantee of competence of any health care professional, the mere presence of such information does not imply a practitioner is not competent or qualified.

Access to high volumes of Provider Credential Search data is available at our open data portal. It gives users a variety of searching, filtering, and data exporting options. We implemented this system to better serve our high-volume customers.

Provider Details

The Washington Department of Health presents this information as a service to the public. This site provides disciplinary actions taken and credentials denied for failure to meet qualifications. If the Enforcement Action column is 'No', there has been no disciplinary action. It allows viewing and downloading of related legal documents since July 1998. Contact our Customer Service Center at (360) 236-4700 for information on actions before July 1998. This information comes directly from our database. It is updated daily.

This site is a Primary Source for Verification of Credentials.

NEW SEARCH RESULTS

Credential Information for: Pieper, Kevin L

Credential	Credential Type	First Issue Date	Last Issue Date	Expiration Date	Credential Status	Enforcement Action
MD00044374	Physician And Surgeon License	11/30/2004	11/28/2017	01/23/2020	ACTIVE	No

Exhibit 25
Kadlec Educational Partnerships

Kadlec Educational Partnerships

Educational Area	School Name	Program	Approx. students
Emergency Medicine	Life Flight	Licensed Paramedics	11
	AMR	Licensed Paramedics	4
	Benton County Fire #4	Licensed Paramedics	13
	Benton County Fire #6	Licensed Paramedics	2
	NMETC	Paramedic Certification	4
	Mission Support Alliance	Licensed Paramedics	13
	Pasco Fire Dept	Licensed Paramedics	2
	Richland Fire Department	Licensed Paramedics	16
	Columbia Basin College	Paramedic Certification	19
	Columbia Basin College	EMT	11
Imaging	Bellevue College	Ultrasound	2
	Bellevue College	Nuclear Medicine	5
	OIT	Radiology Tech	5
	OIT	MRI	1
	OIT	Nuclear Medicine	3
	OIT	Ultrasound	2
	Spokane Community College	Ultrasound	2
	Spokane Community College	Cardiovascular Tech	1
	Columbia Basin College	MRI/CT	9
	Columbia Basin College	Radiology Tech	21
	Columbia Basin College	Mammography	4
Medical	A.T. Still University	Medical	1
	University of North Texas	Medical	2
	Oregon Health Science University	Medical	2
	PNWU	Medical	32
	Rocky Vista University	Medical	2
	WSU	Medical	30
	University of Washington	Medical	16
	Western University of Health Science	Medical	2
Mid Level Medical	Bethel University	Physician Assistant	1
	Heritage University	Physician Assistant	2
	Idaho State Univ	Physician Assistant	9
	Pacific University	Physician Assistant	10
	Rocky Mountain College	Physician Assistant	1
	Rocky Mountain Univ	Physician Assistant	1
	Sullivan University	Physician Assistant	1
	University of Washington	Physician Assistant	6

Educational Area	School Name	Program	Approx. students
Nursing	Blue Mountain Comm College	ADN	6
	Big Bend Comm College	ADN	3
	Lewis-Clark State College	BSN	3
	OHSU	BSN	5
	Sumner College	ADN	1
	University of Jamestown	BSN	1
	Walden University	MSN	1
	Western Governor's University	Masters Nursing	1
	Columbia Basin College	ADN	99
	Columbia Basin College	RN-BSN	1
	Washington State University	BSN	96
	Washington State University	RN-BSN	7
	Washington State University	Nurse Refresher	3
	Walla Walla Community College	ADN	25
	Prosser Memorial Hospital	staff training	1
	St. Anthony's	staff training	2
	Good Shephard	staff training	2
	Lourdes	staff training	2
	University of Cincinnati	Nurse Practitioner	4
	Concordia University	Nurse Practitioner	1
	East Carolina University	Neonatal Nurse Practitioner	1
	Gonzaga University	Nurse Practitioner	4
	Maryville University	Nurse Practitioner	6
	Simmons College	Nurse Practitioner	1
	University of South Alabama	Nurse Practitioner	4
Pharmacy	St. Mary's	Residents	3
	Washington State University	Pharmacy	20
	South Dakota State Univ	Pharmacy	1
Rehabilitation	Washington State University	Speech Therapy	1
	NOVA Southeastern Univ	Speech Therapy	3
	Univ of Northern Colorado	Speech Therapy	1
	A.T. Still	Physical Therapy	1
	Des Moines University	Physical Therapy	1
	Eastern Washington Univ	Physical Therapy	6
	Idaho State Univ	Physical Therapy	1
	Regis University	Physical Therapy	2
	Rocky Mountain Univ	Physical Therapy	3
	Shenandoah Univ	Physical Therapy	1
	Spokane Falls Comm College	Physical Therapy	2

Educational Area	School Name	Program	Approx. students
Rehabilitation	Univ Nevada Las Vegas	Physical Therapy	1
	Univ New Mexico	Physical Therapy	2
	Univ of Utah	Physical Therapy	3
	University of Washington	Physical Therapy	5
	Walsh Univ	Physical Therapy	1
	Whatcom Comm College	Physical Therapy	1
	Wingate Univ	Physical Therapy	1
	Univ of Nebraska MC	Physical Therapy	3
	Pacific University	Physical Therapy	5
	George Fox Univ	Physical Therapy	2
	Chatham University	Occupational Therapy	1
	Creighton Univ	Occupational Therapy	2
	Eastern Washington Univ	Occupational Therapy	1
	Gannon Univ	Occupational Therapy	1
	Huntington University	Occupational Therapy	1
	Linn Benton Comm College	Occupational Therapy	1
	Rush University	Occupational Therapy	1
	Spokane Falls Comm College	Occupational Therapy	3
	Univ of Mary	Occupational Therapy	3
	Univ of St Augustine	Occupational Therapy	10
	Green River College	Occupational Therapy	2
	Linfield College	Exercise Science	1
	Central Washington Univ	Exercise Science	1
Social Work	Walla Walla Univ	Social Work	2
Health Informatics	Columbia Basin College	Health Informatics	22
	Western Governor's University	Health Informatics	1
Medical Coding	Perry Tech	Medical Coding	2
Medical Assistant	Charter College	Medical Assistant	55
	Perry Tech	Medical Assistant	4
	Walla Walla Community College	Medical Assistant	1
	Columbia Basin College	Medical Assistant	20
Clinical Lab	Heritage Univ	Clinical Lab	4
	Weber State Univ	Clinical Lab	2
	Tri-City Labs	Staff Training	2
	Columbia Basin College	Phlebotomy	16
High School Programs	Kennewick School District	High School Work-Based Learning	5
	Richland School District	High School Work-Based Learning	16
Nutrition/Dietetics	Central Washington Univ	Dietetic	2

Educational Area	School Name	Program	Approx. students
Other	Eastern Illinois Univ	Health Promotion	1
	Columbia Basin College	Dental Hygiene	15
	Columbia Basin College	Spanish Interpreter	78
	Columbia Basin College	Surgical Tech	9
	Columbia Basin College	Central Service Tech	4

Exhibit 26
Patient Transfer to Other Health Care Facilities Policy

Origination:	*12/1987*
Last Approved:	*09/2017*
Last Revised:	*09/2017*
Next Review:	*09/2020*
Owner:	*Debra Langston: Director, Risk Mgmt*
Policy Area:	*Patient Care Services*
References:	

Transfer to Other Health Care Facilities, 699.18.00

Document Type: Policy, Procedure

(FORMERLY #1015)

PURPOSE:

In accordance with Federal Statute 9121 of the Consolidated Omnibus Budget Reconciliation Act (COBRA), Public Law 99-272, now known as the "Emergency Medical Treatment and Active Labor Act" or EMTALA, the following policies apply to transfer of patients to other acute health care facilities from ER or other areas i.e. OB where medical screening may occur: (includes skilled nursing facilities)

The Emergency Department physician or the attending physician (if responsible for certifying a patient transfer) shall:

A. ensure that an appropriate medical screening examination was performed for the patient in order to determine if an emergency medical condition exists;

B. certify on the Patient Transfer/Physician orders form that the benefit to the patient outweighs the risk of the transfer;

C. document on the Patient Transfer/Physician orders form the basis of the certification;

D. obtains informed consent for the transfer from the patient or legal responsible person;

E. contact the receiving physician to establish acceptance of the patient and document the name of the receiving physician and the time of acceptance on the Patient Transfer/Physician order form

DEFINITIONS:

1. A. **Emergency Medical Condition**: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse), such that the absence of immediate medical attention could reasonably be expected to result in:
    1. placing the health of the individual (or, with respect to a pregnant woman, the woman or her unborn child) in serious jeopardy; or
    2. serious impairment to bodily functions; or
    3. serious dysfunction of any bodily organ or part; or,

   B. With respect to a pregnant woman who is having contractions

1. there is inadequate time to effect a safe transfer to another hospital before delivery; or
2. the transfer may pose a threat to the health or safety of the woman or unborn child.

2. **Stabilize** (with regard to an emergency medical condition): to provide such medical treatment as necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient from the hospital, or with respect to a pregnant woman who is having contractions, to deliver (including the placenta).
   a. For psychiatric conditions or symptoms of substance abuse, a patient is considered stable for transfer or discharge when he or she is protected and prevented from injuring himself or others.
3. **Appropriate transfer** is one in which:
   a. the transferring hospital provides medical treatment within its capacity that minimizes the risks to the patient's health and, in the case of a woman in labor, the health of the unborn child.
   b. the receiving facility has:
      1. available space and qualified personnel for the treatment of the patient;
      2. agreed to accept the transfer and provide appropriate medical treatment.
   c. the transferring hospital provides the receiving facility with copies of all appropriate medical records of the examination and treatment performed. If test results or other records are not available at the time of transfer, they should be sent as soon as practical after the transfer.
   d. the transporting personnel are qualified and the necessary transportation equipment for life support is also transported with the patient.

PROCEDURE:

1. Hospital staff to notify PCS, Nurse Director or designee of transfer out.	1. The PCS, Nurse Director or designee contacts the receiving facility to discuss pending transfer.
2.Label forms with the patient identifier information (Form #0022, Form #0023) and place on the front of the chart.	2. Pt. Transfer Forms
3.Complete the "Patient Transfer/Hospital Documentation forms.	
Benefit of Transfer V.S. risk of transfer:	
a. Document why the transfer of the patient is necessary (i.e.; unavailability of services at this facility such as burn unit etc; diagnostic equipment downtime.) OR Patient/authorized persons request, after being informed of the hospital's obligation under COBRA and the risk of the transfer. Documentation must indicate reasons for request as well as indicate that the patient is aware of the risks and benefits of transfer AND To document the risks of transferring or not transferring and how the benefit outweighs the risk.	

b. RE: accepting hospital, documentation to be sent with patient or forwarded to receiving facility, consent to transfer.	
4. Prepare documents to be sent with the patient.	
5. Prior to transfer check to see that the physician and staff complete the forms.	5. Use the forms, as a checklist to assure that the documentation is complete.
6. Place the original of the forms in the record. Send the copy with patient's medical record to the receiving facility. Seal the copy in an envelope.	
7. PCS, Nurse Director or designee: a. Contact the receiving facility to assure that the facility accepts the transferred patient. Contact the PCS or equivalent in the receiving facility to assure an authorized person accepts the patient. b. Document on the Patient Transfer/Physician order for the: ◦ name of the person accepting the patient and title; ◦ date; ◦ time; ◦ sign your name in the “Confirmed by” space.	7. Transferal of a patient to a facility without prior acceptance is a EMTALA Law violation.

Key Points

Why do we need these forms?	To help physicians and hospital staff comply with EMTALA obligation and document the necessary patient information. When it is determined that (based on the documentation or lack of documentation) the hospital did not comply with its EMTALA obligations, the Center for Medicare/Medicaid Services (CMS) can terminate the hospital's participation in the Medicare and Medicaid Programs and the Office of Inspector General may fine the hospital and/or the responsible physician $50,000 per violation. Such fines are not covered by liability insurance.
What documentation isnecessary?	The patient's medical condition, stability, and consent; orders for in-transit, risks vs. benefits of transfer; acceptance by the receiving physician and health care facility, and the vital signs of the patients at the time of the transfer.
Who is responsible **by law** for the documentation?	The physician is accountable for the information in Form #0022. The hospital is responsible for the other sections.
Which patients need forms initiated?	All ER patients sent to another acute health care facility via ambulance/transport/ escort for admission or outpatient procedures **AND** patients returning to another facility via such transport after outpatient procedures at Kadlec (if from ER).
	All OB patients who are sent to another acute health care facility for admission directly from the OB unit. (This does not include patients that have been admitted to OB at KMC and transferred as a continuum of care or those OB's who may receive

	initial medical screening from OB and need immediate transfer to another acute care facility)
Other than nursing staff, who needs to know about transfers?	The PCS, Nurse Director or designee needs to know so that the receiving facility can be contacted and acceptance of the patient can be documented. Nursing staff notifies the PCS after the order is written.

Attachments:

No Attachments

Approval Signatures

Approver	Date
Kirk Harper: VP, Nursing & CNO	09/2017
Crystal Wise: Administrative Assistant	09/2017
Debra Langston: Director, Risk Mgmt	08/2017

Applicability

Kadlec Regional Medical Center

Exhibit 27
Organizational Plan for Provision of Care Policy

Origination:	*05/1999*
Last Approved:	*12/2017*
Last Revised:	*12/2017*
Next Review:	*12/2020*
Owner:	*Heather Shipman: Executive Assistant (KRMC Chief Executive*
Policy Area:	*Administration*
References:	

Organizational Plan for the Provision of Care, 130.00

PURPOSE:

The purpose of the Kadlec Regional Medical Center Plan for the Provision of Care is to establish a framework for planning, directing, coordinating, providing, and improving health care services so that they are responsive to community and patient needs and improve health outcomes. The plan serves as a basis to:

1. Identify existing and new patient care services.
2. Direct and integrate patient care and support services throughout the organization.
3. Implement and coordinate services among departments.
4. Demonstrate improvement in the services provided.
5. Direct and support comparable levels of patient care throughout the medical center.

The Plan is a reference used by the organization's leadership team, staff, and physicians to plan, implement, evaluate, and improve services to patients and the community.

Medical Center Information:

Kadlec Regional Medical Center is a 270-bed general medical/surgical facility that has served the community since 1944. Patient Care Services are provided at the following locations in Tri-Cities, Washington:

Mission:

Provide safe compassionate care.

Vision:

Simplify health for everyone.

Promise Statement:

Together, we answer the call of every person we serve: Know me, care for me, ease my way.

Core Outcome:

Creating healthier communities together.

Values

Safety –Safety is our highest priority and is the core of every thought and decision.

Respect – We treat everyone with acceptance and honesty, valuing individual and cultural difference.

Integrity – We earn the trust of the community through ethical behavior and transparency.

Stewardship– We believe that everything entrusted to us is for the common good. We strive to care wisely for our people, our resources and our community.

Compassion– We reach out to people in need and give comfort. We nurture the spiritual, physical and emotional well-being of one another.

Excellence – We hold ourselves accountable to the highest standards of quality and safety.

Collaboration – We join together and with others across the community to advance the interest of the patient and the family.

PURPOSE:

To be the medical center of choice by providing exceptional patient care and service to the region.

AUTHORITY AND RESPONSIBILITY:

A. The organization is authorized to function as an acute care facility by virtue of the acceptance of its Articles of Incorporation by the Secretary of State, and by its licensure and certification by the Department of Health Services. Specific responsibilities are outlined below.

B. Governing Body:
The organization is governed by a Board of Directors (BOD), which is comprised of key leaders of the organization, the medical staff, and members of the community. The BOD has outlined specific duties and responsibilities in its bylaws, policies, and resolutions. In general, the BOD provides for the coordination and integration among leaders to:

1. Establish policy
2. Maintain quality patient care
3. Provide for necessary resources
4. Establish a medical staff and assure appropriate participation by that medical staff in governance matters that affect the medical staff
5. Comply with law and regulation
6. Establish a criteria-based process for selecting the Chief Executive Officer (CEO)
7. Resolve conflict.

C. KRMC Chief Executive

1. The Board of Directors (BOD) and Chief Operating Officer, Eastern Washington/Montana Market, Southeast Washington Service Area empower the KRMC Chief Executive to be responsible for managing the hospital. Specific responsibilities include:
   - Establishing effective operations
   - Establishing information and support systems
   - Recruiting and maintaining staff
   - Conserving physical and financial assets
   - Complying with law and regulation
2. To accomplish these functions, the KRMC Chief Executive has formed a senior leadership team known as the "Executive Team".

D. Executive Team

1. The major responsibilities of the Executive Team include, but are not necessarily limited to the following:
   - Ensuring that the organization provides care and service in a timely manner to meet patient care needs
   - Setting performance improvement priorities and identifying how the organization will adjust its priorities in response to unusual or urgent needs
   - Developing an annual operating budget and long-term capital expenditure plan
   - Providing for a uniform performance of patient care processes
   - Ensuring that each department has a written scope of service and provides care according to its goals and scope of service
   - Collaborating with other relevant personnel in decision-making

- Developing programs for recruitment, retention, development, and continuing education of staff
- Considering the use of clinical practice guidelines in the provision of care.

2. To assist in accomplishing these functions, the Executive Team has formed departments within the organization and has appointed an individual to oversee each department. These individuals are known collectively as "Managers." Department Managers report to Directors, who oversee multiple departments.

E. Department Directors

1. The major responsibilities of department Directors include, but are not necessarily limited to the following:
   - Integrating the departments service with the primary functions of the organization
   - Coordinating and integrating services within their department and with other departments
   - Developing and implementing policies and procedures that guide and support the provision of services
   - Recommending a sufficient number of qualified and competent persons to provide care
   - Determining the qualifications and competence of department personnel who provide patient care services
   - Continually assess and improve their department's performance
   - Maintaining appropriate performance improvement and quality control programs
   - Providing for orientation, in-service training, and continuing education of staff
   - Recommending space and other resources needed by the department
   - Participating in the selection of outside resources for needed services.

F. Medical Staff

The BOD has authorized the establishment of a medical staff. The medical staff is self-governing in accordance with its bylaws, rules and regulations, policies and procedures. The specific duties and responsibilities of the medical staff are outlined in the aforementioned documents and will not be repeated here.

G. Services Provided

1. Consistent with its licensure and mission, the organization provides the following services:
   Inpatient & Outpatient Services.
2. Services not directly provided by the organization are provided through contractual/referral arrangements with other providers of care to assure that patient care needs are met.

H. Related Plans and Documents

The organization has developed additional planning documents that further describe its approach to managing key functions in the organization. These plans include, but are not limited to the following:

1. Organizational Plan for the Provision of Care (Policy 130)
   - Describe Mission and Purpose authority and responsibility, department structure, services provided, staffing structure for each department.
2. Organization Coordinated Quality Improvement Plan (Policy 815)
   - Describes the organization's approach to improving care and services provided.
   - Each department develops an annual Performance Improvement plan comprised of key quality, service and cost indicators and performance improvement goals.
   - Each department makes an annual Performance Improvement presentation to the Performance Improvement Council.
3. Patient Safety Plan (Policy 817)
   - Describes the organization's approach to reducing errors in the provision of care.
4. Information Management Plan (location: VP Information Systems)
   - Describes the organization's plan for current and future information needs.
5. Human Resources policies and procedures describe the organization's approach to orientation, training and competency assessment.
6. Environment of Care Management Plans (location: Plant Operations)
   - Describes how the organization plans for the environment of care in the following areas:
     - safety and security management
     - security management
     - hazardous materials/waste management
     - fire safety (life safety)
     - emergency management
     - medical equipment management
     - utilities management

PROCEDURE/PLANNING:

A. The planning process begins with the establishment and communication of the organization's mission, vision, and values. Guided by these statements, the leaders assess the needs of the community, patients, medical staff, hospital staff, and other key stakeholders. Once needs have been determined, leaders develop and implement strategic and operational plans to meeting those needs.

B. Prioritization Criteria

It is necessary to prioritize how and where resources will be allocated to meet identified needs. In applying criteria, leadership is sensitive to emerging needs, such as those identified through data collection and assessment, changing regulatory requirements, significant patient and staff needs, changes in the environment of care, or changes in the community.
The following criteria are used to assist leaders in prioritization activities:

1. Ensure the safety of the environment of care
2. Ensure the safety of the providers of care and the recipients of care
3. Meet legal, regulatory, licensure, and accreditation requirements
4. Further the mission and strategic objectives of the organization
5. Establish desirable outcomes of care for at-risk patient populations
6. Establish the effectiveness, timeliness, and stability of processes that are high-risk, high-volume, or problem-prone
7. Determine the effectiveness of the design of new or modified services.

C. Space and Facilities

The planning process also ensures configuration and allocation of all necessary resources, including space, equipment and other facilities to meet specific needs of the patient populations served. The goal of the planning process is to provide effective and efficient patient care by maximizing resource utilization.

D. Identification of Important Functions

Planning also takes into account ensuring that the important functions of the organization are effectively designed, implemented, and evaluated. The organization complies with The Joint Commission (TJC) standards and regulatory requirements in developing policies and practices that address key processes and activities within each function area.
Those important functions are as follows:

1. Patient focused functions
   - ethics, rights and responsibilities
   - provision of care, treatment, and services
   - medication management
   - surveillance, prevention, and control of infection
2. Organization focused functions
   - leadership
   - improving organization performance
   - management of the environment of care

- management of human resources
- management of information

3. Structures that support functions
   - medical staff
   - nursing

E. Department Scopes of Services/Policies and Procedures
Each department is designed to provide an important aspect of care or service. In order to ensure that care and service is provided in a consistent, effective, and reproducible manner, each department has developed a written scope of service as well as department policies and procedures. The process for developing these documents considers at least the following:

1. the types and ages of patients served
2. methods used to assess and meet patient care needs
3. the scope and complexity of patient care needs
4. the appropriateness, clinical necessity, and timeliness of support services provided directly by the organization of through referral contacts
5. the availability of necessary staff
6. the extent to which the level of care or service provided meets patient needs
7. recognized standards or practice guidelines, when available.

F. Integrating Care
Patients receive care by passing "horizontally" through the care delivery system. Hence, the planning process also ensures that care provided by departments is integrated throughout the organization. Processes to ensure integration of care include, but are not limited to:

1. establishing multidisciplinary care-teams and committees to address patient care issues
2. developing organization-wide policies that address important patient care issues to ensure a "single standard of care"
3. establishing forums for the communication of issues and information between and among departments
4. developing and monitoring performance measures that address coordination and integration of care
5. ensuring the competency of providers of care wherever such care is rendered
6. development of department policy and procedure in collaboration with other departments.

G. Communication and Collaboration
The organization uses a variety of mechanisms to foster communication and collaboration among and between departments and services. Such mechanisms include, but are not limited to:

1. Patient Care Services meetings
2. committee meetings, i.e. Patient Safety, Safety
3. multidisciplinary performance improvement teams
4. management meetings, division meetings, department meetings, team meetings
5. newsletters and email
6. written memorandums and other documents

H. Staffing
The organization recognizes its responsibility to ensure sufficient numbers of qualified staff to meet its mission and scope of services. To accomplish this, each department has developed a staffing plan. The plan addresses the following:

1. the number and qualifications of staff necessary for the department to safely perform minimal operations
2. identification of the work driver that results in the need to increase the number/qualifications of staff to meet the increased workload of the department
3. the mechanism by which staffing will be adjusted to meet changes in the work driver
4. mechanisms to bring in additional staff if so required
5. mechanisms to call off staff if so required
6. indicators that can be measured to determine the effectiveness of staffing levels.

Staffing levels are monitored on a regular basis to ensure an appropriate utilization of resource. Variances to staffing are documented, along with an analysis of why the variance occurred, what actions were taken to address the variance, and the impact on patient care.

SERVICE INDEX:

Administration/Strategic & Business Planning Process
Index
Acute Care Services
Anti-Coagulation Management Program
CardiacAcute Care Unit
Cardio Pulmonary Rehabilitation
Clinical Decision Unit
Clinical Laboratory
Clinical Resource Management
Coding
Community Relations/Marketing
Compliance & Audit
Diabetes Learning Center
Diagnostic Imaging & Cardiac Care Services
Education
Emergency Department
Finance
Genetic Counseling
Health Information Management
Human Resources
Infection Prevention
Information Technology Division
Inpatient Rehabilitation
Inpatient Wound and Ostomy Care
Intensive Care Services
Kadlec Clinic

Maternal Child Services

Neurodiagnostics

Neuroscience Center

Nutrition Services

Outpatient Procedures

Patient Access/Central Scheduling

Patient Financial Services

Perioperative Services

Pharmacy

Plant Operations

Quality Care Management

Resource Team

Respiratory Care

Risk Management

Supply Chain Management

Therapy Services

Value Improvement for Patients Resource Office

Wound Healing Center

Continuum of Care

ACUTE CARE SERVICES:

6 River Pavilion, 7 River Pavilion , 8 River Pavilion, and Surgical

Scope of Service

Mission and Purpose

Acute Care's priority is to provide quality, cost-effective, patient centered care to our community and surrounding areas. The staff works together as a team in a professional and collaborative environment to improve health and the quality of life during all phases of the illness and recovery process.

Authority and Responsibility

Under the general direction of the Director of Acute Care Nursing, the Unit Manager:

- directs implements, assesses and evaluates the timely and appropriate delivery of patient care,
- collaborates with appropriate medical staff for the overall planning of patient care across the care continuum,
- participates in the development of nursing standards consistent with current nursing research and nationally recognized professional standards; ensures standards are being met,
- participates in the Medical Center planning that considers community health needs and results in development of strategic initiatives supporting the mission and vision,
- is responsible for the day to day operation of the nursing unit,
- ensures quality patient care by establishing and maintaining clinical standards of practice and care while meeting unit staffing requirements,
- performs all aspects of human resource management including interviewing, hiring, and counseling,
- is responsible to assess, plan and evaluate the unit orientation and education requirements and assure that they are met,
- Is responsible for the annual budget preparation including operational and capital items,
- assures that hospital policies and procedures are updated,
- participates and coordinates unit and organizational quality improvement activities,
- maintains clinical nursing skills,
- appropriately intervenes in patient, family and physician issues in a timely manner, and
- supports and demonstrates the mission, vision and values of Kadlec Regional Medical Center.

Nursing Staff is provided an extensive orientation that includes advanced cardiac rhythm training.

Staff is responsible for assisting with the learning needs of new nurses, temporary help, and students on the units. Specialty certification is recommended, but not required.

Any physician on staff may admit to the units. Telemetry patients in the following unit (4 River Pavilion, 6 River Pavilion, Surgical, Inpatient Rehabilitation, Intensive Care Unit, Emergency Department, Pediatrics, Birth Center, Clinical Decision Unit) are monitored at a central location on 4 River Pavilion. Telemetry technician responsibilities include, but are not exclusive to: rhythm identification, documentation of cardiac rhythms, notification of rhythm changes to primary nurse and lethal rhythms called to lead nurses via Nextel PTT (push to talk) function.

Department Structure:

The Acute Care Units include:, 6 River Pavilion, 7River Pavilion, 8 River Pavilionand the Surgical Unit.

The 6 River Pavilion Unit is open 24 hours a day, 7 days a week and is a is a 29 private bed unit. The population served is adult patients requiring care for medical conditions that are not in need of intensive care services. All rooms are capable of bedside cardiac monitoring with central monitoring as well. All rooms can accommodate isolation patients. Oxygen, vacuum, emergency power outlets, dialyis and a nurse call system are available in all rooms

The 7 River Pavilion and 8 River Pavilion Units are open 24 hours a day and are 27 private units. The population served is adult patients requiring care for medical conditions that are not in need of intensive care services. All rooms are capable of bedside cardiac monitoring with central monitoring as well. All rooms can accommodate isolation patients. Oxygen, emergency power outlets, dialysis and a nurse call system are available in all rooms.

The Surgical Unit is located on the fourth floor in the Orchard Pavilion. It is a 37 private bed unit that provides services 24 hours a day, 7 days a week. The population served is primarily orthopedic, neuro (spine), general surgery, gynecologic, and urology patients. All rooms care capable of bedside cardiac monitoring with central monitoring as well. All rooms can accommodate isolation patients. Oxygen, suction, emergency power outlets and a nurse call system are available in all rooms.

Staff and physicians may access needed services through consulting with respiratory, pharmacy, nutrition services, cardiac rehab, wound services, chaplaincy, PT/OT/Speech or Social work services.

Patient and family education occurs throughout the stay. Topics include current management of disease or procedure, as well as symptoms to watch for in the future.

Organizational Structure

Vice President of Nursing/Director of Acute Care Services/Unit Manager/Clinical Educator.

6 River Pavilion			**7 & 8 River Pavilion**			**Surgical**		
Skill	Days FTE	Nights FTE	Skill	Days FTE	Nights FTE	Skill	Days FTE	Nights FTE
Lead	1.0	1.0	Lead	1.0	1.0	Lead	1.0	1.0
RN	6.0	6.0	RN	6.0	2.0	RN	8.0	8.0
CNA	3.0	3.0	CNA	3.0	1.0	CNA	4.0	4.0
Unit Secretary	1.0	1.0	Unit Secretary	1.0	1.0	Unit Secretary	1.0	
Unit Manager	1.0		Unit Manager	1.0		Unit Manager	1.0	

Staffing matrix is a guideline and is based off the patient's acuity as determined by the use of the Patient Needs Assessment Tool. Patients with a high patient need may have a nurse patient ratio of 1:4-5. Patient requiring less intensive care will have a nurse to patient ratio of 1:5-6.

Key Department Relationships

The Acute Care Units and the Surgical Unit work closely with Respiratory, Pharmacy, Nutrition Services, Therapy Services, Wound Care and Social Work Services to assure that patient care needs are met.

Scope of Service

Twenty-four hour nursing care is provided based on Washington State Nurse Practice, Medical Center policy/procedure, standards and American Academy of Medical/Surgical Nursing standards. The RN is responsible for assessing, planning, evaluating, teaching and delegating. The LPN assists with data gathering, planning, evaluating, teaching and delegating. The CNA is responsible for patient ADLs as delegated. The unit secretaries greet patients and family conduct daily unit upkeep tasks, and generally assist charge nurses. There is a charge nurse assigned to each shift. This individual has demonstrated leadership skills and the ability to have an objective overview of the department on a shift to shift basis. Patient assignments are made based on patient care need and determined by utilizing the Patient Needs Assessment Tool, continuity of care and skill mix of staff.

Medical Direction for the Acute Care Units (4 River Pavilion, 6 River Pavilion, 7 River Pavilion, 8 River Pavilion, Surgical) is provided by the Department Chairs of Medicine, Surgery, and Family Practice and the Medical Director of the Hospitalist Program.

Services Provided

The following guidelines are used to categorize patients admitted to or considered to be admitted to the Acute Care Units. Patients may be admitted to any of the departments dependent of bed availability.

The following guidelines are used to categorize patients admitted to or considered to be admitted to Surgical or the Acute Care Units

1. Patients appropriate for **Surgical** admission are:
    - Surgical inpatient procedures
    - Surgical outpatient observations (consider CDU first for post surgical observations).
    - Surgical patients requiring telemetry monitoring.
    - Surgical patients with cardiac drips such as Cardizem and Dopamine
    - Surgical patients with PCAs, epidurals, or intrathecal lines.
    - Pre and post surgical procedures which includes Ortho, Neuro, GYN, Urology, General surgery, and ENT.
    - Surgical patients age 14 years and older.
2. Patients appropriate for the Acute Care Units admission are:
    - Oncology - inpatient and outpatient chemotherapy
    - Medical patients requiring telemetry monitoring
    - Medical patients with drips such as Cardizem and Dopamine
    - Medical observations (consider CDU first for medical observations).
    - Cardiology
    - Pulmonary
    - GI
    - General medical
    - Endocrine

Staffing Guidelines

Acute Care Units

Indicator	Criteria
A. Patient Needs Assessment	The Patient Needs Assessment will be completed every shift to provide acuity criteria for the charge nurse to utilize for staffing decisions.
B. Patient Assignment	Patients with higher acuity will be assigned to the more experienced nurse on duty.
C. Staffing Guidelines A staffing matrix determines staffing for each shift that is based on budgeted nursing hours per patient day and minimum staffing standards. The Acute Care Unit RN to patient ratio is 1:4-5 on days and 1:5-6 on nights. Staffing may be under the matrix when most patients have a lower acuity. Patient needs that effect staffing include: • High patient needs as determined by the Patient Needs Assessment Tool • Patients in restraints (>1 patient) • Patients in isolation, confused (requiring isolation cart, more than three patients.) • Large percentage of high fall risk or bariatric/limited mobility patients • Patients requiring a large amount of emotional support (i.e. dying patients, major psychological or social issues) • 1:1 patients such as suicide or major safety risks • IV drips (cardizem, dopamine, etc.) required to maintain hemodynamics • Insulin drips and frequent blood sugars • Complex chemotherapy protocols (multiple timed, IV meds) • New chemotherapy patient requiring significant patient education • Acute leukemia inductions • Large percentage of float staff, new agency staff, or inexperienced nurses • Alcohol/drug withdrawal • Medically unstable patient requiring assessments > every1-2 hours • More than 5 admissions/post-ops in 4 hours	

Prior to June 23, 2010, the Acute Care Units were referred to as:

Previous Unit Name	Current Unit Name
Medical	3 Orchard Pavilion
Surgical	Surgical
	6 River Pavilion opened 6/23/2010 8 River Pavilion opened 10/4/16 7 River Pavilion opened 12/13/16

ANTI-COAGULATION MANAGEMENT PROGRAM:

Scope of Service

Mission and Purpose

The mission of the Anti-Coagulation Management Program is to provide high quality, individualized assessments to patients in an ambulatory setting using evidence-based practices. The goal is to maintain the anticoagulation patients in a therapeutic range to prevent both bleeding and blood clotting.

Authority and Responsibility

The Manager reports to the Director h who reports to the Vice President of Professional Services. The Vice President of Professional Services reports to the KRMC Chief Executive. The manager is responsible for daily operations of the department, program development, and the implementation of department goals and objectives. The manager ensures that quality patient care is provided by appropriate staffing and establishes and maintains clinical standards of practice. The manager performs all aspects of personnel management including interviewing, hiring, and employee coaching and counseling. The manager is responsible for budget preparation and management of cost effective practices in the department. The manager assures that policies and procedures are updated and participates in department and organizational quality improvement activities. Collaboration with physicians is available directly with referring physicians as well as through the medical director.

Department Structure

The Department is physically located at the Healthplex, 1268 Lee Boulevard and a satellite clinic at Kennewick Primary Care. The hours of operation are from 7:00 a.m. to 5:30 p.m. Monday through Friday (closed holidays).

Services Provided

The LPN, RNs and advance registered nurse practitioners work within the scope of practice and provide the following services, depending on the patient population:

History and physical examination

Review of medications, allergies and nutritional status

Anticoagulation Management for persons prescribed antithrombotic medications.

Patient instruction and education

Patient Populations Served

Anti-Coagulation Management Program staff serve patients residing within the regional area served by Kadlec Regional Medical Center. The department provides outpatient consultation and care to patients of all ages and socioeconomic levels. Patients who are being monitored for the therapeutic effects of anticoagulation medications make up the specialty populations served. The department also provides inpatient anticoagulation education for all patients that are on warfarin.

Mechanism to identify patient care needs

Patient care needs are initially identified on the referral form which indicates any physical limitations, and language barriers. Arrangements are made to ensure clear communication during all visits at the Department. An education assessment is completed on the initial visit and education is continued through discharge. A teaching plan and educational literature is available for anticoagulation therapy.

Staffing Structure

Staffing is provided by Advanced Registered Nurse Practitioners, Registered Nurses, Licensed Practical Nurses, and Office Assistants. Clinic aides and summer interns may also be used to supplement staffing in the department. A manager is budgeted to provide leadership and management part time and patient care part time. Staffing includes ARNPs, an anticoagulation RN, an anticoagulation LPN, and an office assistant. Staffing is flexed based on patient appointments and referrals. The Nurse Practitioner oversees the medical care of the patients. The ARNP provides consultation, treatment and management of the patient's health problems identified. The ARNP also fosters health promotion and disease prevention. The RNs assess, teach, and provide nursing care to the patients. LPN provides nursing care to the patients. The office assistant is responsible for patient registration, appointment scheduling, billing, supply inventory and general office duties to ensure efficient work flow.

Standards

Anticoagulation Service

The Anticoagulation Staff have successfully completed the Anticoagulation Management Program from the University of Southern Indiana School of Nursing and have received their certificate of successful completion. They are responsible for the history and physical examination, patient education about antithrombotic therapy, the evaluation of the patient's International Normalized Ratio and adjustment of medication based upon evidence based protocols.

Key Department Relationships

Anti-Coagulation Management Program interacts with most departments of Kadlec Regional Medical Center. Referrals for inpatient anticoagulation therapy are received from the inpatient units. Outpatient referrals come from healthcare providers in, and beyond, the Kadlec service area. The department collaborates with various disciplines, including but not limited to, physicians, laboratory personnel, etc, to provide a comprehensive plan of care.

CARDIAC/ACUTE CARE UNIT:

4 River Pavilion

Scope of Services

Mission and Purpose

The cardiac/acute care unit's priority is to provide quality, cost-effective care to our community and surrounding areas. We work together as a team to improve health and the quality of life during all phases of the illness process.

Authority and Responsibility

Under the general direction of the Director of Acute Care, the Unit Manager directs, implements, assesses and evaluates the timely and appropriate delivery of patient care. Collaborates with appropriate medical staff for the overall planning of patient care across the care continuum. Participates in the development of nursing standards consistent with current nursing research and nationally recognized professional standards; ensures standards are being met. Participates in the Medical Center planning that considers community health needs and results in development of strategic initiatives supporting the mission and vision.

Under the general direction of the Director of Acute Care, the Unit Manager is responsible for the day to day operation of the nursing unit. The Unit Manager ensures quality patient care by establishing and maintaining clinical standards of practice and care while meeting unit staffing requirements. The Unit Manager performs all aspects of human resource management including interviewing, hiring, and counseling. Will assess, plan and evaluate the unit orientation and education requirements and assure that they are met. Is responsible for the annual budget

preparation including operational and capital items. Assures that hospital policies and procedures are updated and participates and coordinates unit and organizational quality improvement activities. Maintains clinical nursing skills. Appropriately intervenes in patient, family and physician issues in a timely manner. Supports and demonstrates the mission, vision and values of Kadlec Regional Medical Center.

Nursing Staff has progressive care experience or attends education to obtain necessary knowledge. Staff is responsible for assisting with the learning needs of new nurses, temporary help, and students in the unit. PCCN certification is recommended but not required. Life saving measures fall within the nurse's responsibility when a physician is not present. The nurse is authorized to implement standing orders, start IV's; initiate advanced life support, or adjust pacemaker settings if necessary until physician arrives.

The primary admitting physicians for this unit are cardiovascular surgeons, cardiologists and vascular surgeons

Department Structure

The 4 River Pavilion is a 28 private bed CardiacProgressive Care Unit that is open 24 hours a day, 7 days a week. The population served is adult patients requiring stepdown care for medical and surgical conditions that are not in need of intensive care services. All rooms are capable of bedside cardiac monitoring, hemodynamic monitoring, and central monitoring as well. All rooms can accommodate isolation patients. Oxygen, vacuum, emergency power outlets and a nurse call system are available in all rooms.

Services Provided

The Cardiac Acute Care unit is an adult medical-surgical area. Typical patients include post open heart surgery, myocardial infarctions and vascular surgeries.

Multi-disciplinary care is provided which includes daily rounding and goal setting. Staff and physicians may access needed services by consulting with respiratory therapy, pharmacy, nutrition services, PT/OT, speech therapy, social work services, cardiac rehab and chaplains.

Patient and family education occurs throughout the patient's stay. Education includes information about disease management as well as options regarding treatment. When patients are unable to participate in education due to the severity of their illness family members are kept up to date on procedures and given options as to plan of care.

Cardiac services are key to the Chest Pain Center with PCI as accredited by the Society of Chest Pain Centers.

Staffing Structure

Unit Manager, Clinical Educator

Skill	Day FTE	Night FTE
Lead RN	1.0	1.0
RN	7.0	7.0
CNA	3.0	3.0
HUC	1.0	

Staffing is based on acuity. Nurse patient ratios may be 1:3 or 1:4 for cardiac patients. In overflow circumstances a 1:5 ratio may be permissible (medical-surgical patients due to high census on other units).

Staffing Guidelines

A staffing matrix determines staffing for each shift that is based on budgeted nursing hours per patient day and minimum staffing standards. The Acute Care Unit RN to patient ratio is 1:4-5 on days and 1:5-6 on nights. Staffing may be under the matrix when most patients have a lower acuity. Patient needs that effect staffing include:

- High patient needs as determined by the Patient Needs Assessment Tool
- Patients in restraints (>1 patient)
- Patients in isolation, confused (requiring isolation cart, more than three patients.)
- Large percentage of high fall risk or bariatric/limited mobility patients
- Patients requiring a large amount of emotional support (i.e. dying patients, major psychological or social issues)
- Patients requiring large amounts of education.
- 1:1 patients such as suicide or major safety risks
- IV drips (cardizem, dopamine, etc.) required to maintain hemodynamics
- Insulin drips and frequent blood sugars
- Complex chemotherapy protocols (multiple timed, IV meds)
- New chemotherapy patient requiring significant patient education
- Acute leukemia inductions
- Alcohol/drug withdrawal
- Medically unstable patient requiring assessments > every1-2 hours
- More than 5 admissions/post-ops in 4 hours

Key Department Relationships

The Cardiac Acute Care unit works closely with ICU, Cardiac Rehab, Respiratory Therapy, Nutrition Services and Social Work services to assure that patient needs are met. The AMI PI Committee addresses AMI issues throughout the house and region.

Cardio Pulmonary Rehabilitation:

Scope of Service

Mission and Purpose

Mission:

CardioPulmonary Rehabilitation is a blending of exercise therapy, health teaching, medical management and psychological support to safely assist the individual to obtain, re-establish, or enhance his/her optimal physical, psychological, occupational, social and recreational status.

Purpose:

To achieve and maintain the individual's maximum level of independence and functioning in the community via assistance by an interdisciplinary team of specialists by

1. Increasing exercise capacity
2. Educating client and family to concepts and skills that will facilitate successful management of their disease
3. Reducing incidence of medical problems by improving physical condition and increasing knowledge of self-care.
4. Reducing costs by preventing problems that require hospitalization.

Authority and Responsibility

1. The Physician Medical Director Advisor is responsible for supervising revisions of care plans for clients with complicated medical histories, program protocols, standing orders, policies and procedures. He/she is available for consultation regarding client management, acts as an ambassador to other potential referring physicians, and is a resource for ongoing program development.
2. The Physician Supervisor is available and accessible for any emergency at all times the exercise program is conducted.
3. The Director of Therapy Services is responsible for overall operation of the department including program development and the implementation of the department goals and objectives.
4. The CardioPulmonary staff organizes, coordinates, monitors and controls daily operations and activities of the CardioPulmonary Rehabilitation Department, performs direct patient care and performs related duties as assigned by leads and Director.
5. CardioPulmonary Rehabilitation Registered Nurse develops a plan of treatment through the nursing process of assessment, planning, implementation and evaluation; demonstrates exercise equipment and follows through with the treatment as approved by a physician and performs related duties as assigned.
6. The role of the Exercise Specialist is to demonstrate, teach and supervise patients in a series of exercises following a plan of treatment as approved by a physician; assesses and document patients' progress and performs related duties as assigned.
7. Healthplex support staff perform a variety of clerical and receptionist functions and does related work as assigned following department procedures.
8. Other support staff in our multidisciplinary approach includes Social Services, pharmacy, respiratory therapy, dietary, diabetes learning center, and hospital chaplain.

Department Structure

The CardioPulmonary Rehabilitation Department is located at 1268 Lee Boulevard Richland, Washington.

Hours of Service:

- Monday, Wednesday, Thursday Phase II monitored exercise scheduled between the hours of 8:00am – 6:00pm by appointment.
- Tuesday Open gym for Phase III or maintenance patients 6:30am – noon, 12:30pm-4:00pm
- Phase III or maintenance may be seen

Services Provided

CardioPulmonary Rehabilitation participants are those of 18 years or older that are compromised due to documented pulmonary disease or those suffering from a cardiac event that generally includes a myocardial infarction, coronary bypass surgery, stable angina, and/or angioplasty/stent. Occasionally, based on a client's insurance, they may be approved to receive services due to multiple risk factor management.

Cardiac Rehabilitation:

The Phase II service is provided to those eligible clients on an outpatient basis. It begins with an initial interview at which time a client's medical and exercise history is obtained and then a complete overview of our program is described to the client/client's family. An individualized exercise prescription is then prepared for the next session. We ask them to attend three times weekly for their monitored exercise program (phase II). Based on their perceived exertion and our data via telemetry, vital signs, etc. their exercise prescription is advanced by following the guidelines of the American Association of Cardiovascular and Pulmonary Rehabilitation and the American College of Sports Medicine.

Also, based on their performance that day and general well being, suggestions are made for their home exercise program for the following day(s). Educational classes are offered on an ongoing basis.

At the time of discharge from Phase II, individuals have a complete graduation packet indicating the progress they have achieved and suggestions for their home exercise program based on their likes, dislikes, capability, and access to exercise equipment. All clients that have completed their phase II program are invited to attend our phase III program, which meets every Tuesday and Thursday.

Pulmonary Rehabilitation-Format is closely the same as cardiac rehabilitation with these exceptions:

- Clients are monitored via the cardiac telemetry for the first two visits and then generally every sixth visit thereafter
- Oxygen saturation's are taken resting, post each modality, and post exercise

Staffing Structure

CardioPulmonary Rehabilitation Nurses – 3.6 FTE

(2) – 0.75 FTE

A. - 0.6 FTE
(3) - 0.5 FTE

B. – Per Diem

Exercise Specialist – 1.85 FTE

A. - 1.0 FTE – 0.5 FTE + 0.5 FTE for Wellness Program

A. -- 0.85 FTE – 0.60 FTE + 0.25 FTE for Employee Wellness Program

B. – Per Diem

Other Personnel - 0.1 FTE

(Pharmacy/Dietary/hospital chaplain, etc. lectures for education sessions)

Phase II staffing consists of a minimum of two professional staff. Staffing will increase as census/acuity increases. The office assistant is available on a part-time basis to provide the necessary clerical work and answer phones.

Phase III Staffing consists of two multidisciplinary staff with part-time office assistance.

Standards

All staff have CPR cards, meet unit specific competency checks, and is compliant with Skills Fair/HES requirements. It is recommended that the Fitness Specialist become ACLS certified, but it is optional. . The Cardiac Rehabilitation Program is certified through the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR).

Key Departmental Relationships

CardioPulmonary Rehabilitation provides inpatient and outpatient services, and interactions occur between client's, client's families, staff, physician, and ancillary departments to assist with lifestyle modifications. Also, as a service to clients, insurance companies are contacted to determine eligibility for cardiac or pulmonary rehabilitation. The Physician Medical Advisor, Physician Supervisor, and Assistant Vice President of Nursing can all easily be reached via telephone, e-mail, or by scheduling appointments. Also, information can be mailed or faxed to his/her office, as well as communicating with them regarding their visits to the CardioPulmonary Rehabilitation Department.

CLINICAL DECISION UNIT:

Scope of Service

Mission and Purpose

The Clinical Decision Unit (CDU) is a multidisciplinary patient care unit. Care is provided in the unit for patients and their families, working collaboratively with all departments within the facility as well as physicians, whose stay is less than twenty-four hours.

Goals and Services

The goal is to provide patient centered care for individuals with a wide variety of care issues on a short term basis. These conditions include, but are not limited to:

1. Pre and post heart catheterization patients,
2. Outpatient procedures.
3. Patients whose condition can be evaluated/treated within 24 hours and requiring no more than 48 hours of observation care.
4. Pre-op and Post-op services for elective same day surgery.
5. IV therapy that must be completed outside of the service hours of Outpatient Procedure Department.

Authority and Responsibility

Under the general direction of the Director of Peri-Operative Services, the Unit Manager is responsible for the day-to-day operation of the Clinical Decision Unit. The Unit Manager ensures quality patient care by establishing and maintaining clinical standards of practice and care while meeting unit staffing requirements. The Unit Manager performs all aspects of human resource management including interviewing, hiring, and counseling. Will assess plan and evaluate the unit orientation and education requirements and assure that they are met. Is responsible for the annual budget preparation including operational and capital items. Assures that hospital policies and procedures are updated and participates and coordinates unit and organizational quality improvement activities. Keeps current and up to date in nursing trends and issues. Appropriately intervenes in patient, family and physician issues in a timely manner. Supports and demonstrates the mission, vision and values of Kadlec Medical Center.

Department Structure

Location:

The Clinical Decision Unit is a 25-bed unit located on the first floor of the River Pavilion (tower) and a satellite location with 11 beds located on the first floor of the Orchard Pavilion.

Hours of Operation:

The unit is open twenty-four hours a day seven days a week.

Staffing and Structure

Nurse Manager	1
Registered Nurses	31.2
Certified Nursing Assistants	3.6
Unit Secretary/Technician	9.1
	43.9 FTE

Key Customers

Include:

- Patients/families
- Visitors
- Medical staff
- Hospital staff (each other)

Communication

Day-to-day communications occur via email, telephone, face to face, meetings and written memos/information. Participation on hospital committees is encouraged.

Clinical and Pathology Laboratory:

Scope of Services

Mission and Purpose

The Laboratory supports the Mission and Vision of the Medical Center by providing accurate, timely and cost effective diagnostic testing.

Authority and Responsibility

The Laboratory is a support service department certified to perform testing on human specimens under the Laboratory Improvement Amendments of 1988 (CLIA). The Laboratory is licensed to perform waived, moderate, and high complex testing for clinical and anatomical specimens.

The Laboratory Medical Director is responsible and serves as the technical supervisor according to CLIA 88. His services are contracted with Incyte Pathology. Three Pathologists reside locally, one of which is the Medical Director. The Laboratory Director reports to the President of Kadlec Regional Medical Center.

Department Structure and Emergency Services

The Clinical Laboratory, Laboratory Management and Pathology offices are located within the hospital, @ 888 Swift Blvd, Richland, WA.

Clinical Lab is staffed twenty-four hours a day, seven days a week with Phlebotomists, Clinical Assistants, Medical Technologists, and Medical Lab Technicians. All employee personnel requirements meet or exceed all CLIA

requirements of Washington State.

Clinical Lab offers in-house testing necessary to perform hematology, blood bank, urinalysis, coagulation, gram stains, and comprehensive chemistry testing to include kidney, cardiac and liver function tests. Blood Gas analysis is collected and performed by Respiratory Department. Testing is available twenty-four hours a day, seven days a week. See attached test menu.

Pathologists' office hours are 8:30 am – 5:00 pm (M-F), with "on call" after hours.

The Laboratory has multiple back-up plans for emergency testing that include:

- duplicate instrumentation in place for hematology, chemistry, coagulation and urinalysis
- send specimens out to other hospital laboratories located in Pasco and Kennewick
- send specimens out to Tri-Cities Laboratory - Core (TCL-Core) located in Kennewick
- send specimens to PAML reference lab located in Spokane
- perform viable point of care testing

Point of Care Testing

Clinical lab is responsible for in-house Point of Care testing. Point of care testing is available twenty-four hours a day, seven days a week. The Point of Care Supervisor works closely with lab, RT, and nursing staff to maintain Quality Assurance for accurate testing.

Off site departments performing point of care testing obtain their own CLIA license. The Point of Care Supervisor assists and aids in Quality Assurance for accurate testing.

Contracted Services

Testing and services that are not performed or available at the hospital are contracted with the following:

- TCL – microbiology and reference testing
- PAML – reference testing
- ARC – blood services and reference testing
- INCYTE – pathology and medical directorship

CLINICAL RESOURCE MANAGEMENT:

Scope of Service

Mission and Purpose

Clinical Resource Management (CRM) is a department that supports the patient and patient caregivers through the continuum of the patient's stay, assuring that effective resources are available to meet the patient/family needs. CRM's primary customers include patients/families, visitors, medical staff.

- The Case Management team is responsible for utilization management and review, discharge planning and clinical social services. This team coordinates the appropriate level of care and monitors and facilitates access to services and alternative care settings. Coordination of care is a primary function, maximizing efficiency and resources. Social Workers provide an assessment of patients to promote optimal social functioning of the patient. Patients and families are provided options and support in making suitable arrangements for post-hospital care and in planning for current and ongoing expenses.

Authority and Responsibility

CRM Department reports to the Director of CRM and in manager absence, reports to VP Finance/CFO.

Department Structure

The CRM department staff is located in many areas of the hospital; however, primary office is located in Mountain Pavilion, second floor.

CRM Manager, RN	1.0
CRM Admin. Assistant	1.0
Case Manager Specialist (RNs)/MSWs	18.3

Key Departmental Relationships

Department customers served are both external and internal which include: hospital administration, managers and staff; Medical Staff; patients and families, contracted services and vendors, insurance companies and government payers, DOH and other regulatory agencies, multiple community contracts are customers such as healthcare agencies and providers.

Clinical Resource Management is a service department that interacts with and supports every patient care department in the organization. Key customers include all nursing departments, medical staff, clinical staff and Financial Services.

Standards

RN staff members maintain a current Washington State Nurse's License. Social Workers are masters prepared. All CRM staff maintain current CPR certificate.

Coding:

Mission and Purpose

The coding department is responsible for all aspects of Coding (e.g. Inpatient, Outpatient ASU, Observation, Emergency, Diagnostic, Series, Wound Care) in compliance with state and federal regulations ensuring the highest level of patient, employee, physician and customer satisfaction with ethical standards. The department works to continuously improve services and ensure they are performed in a professional manner with integrity and respect.

Standards

The coding department coding standards are established according to ICD-10 Coding guidelines. The department also complies with federal and state regulations established by the Centers of Medicare/Medicaid and Washington State Legislature. Additionally Coding maintains task specific standards for performance volumes and accuracy as defined in departmental policies and procedures.

Authority and Responsibility

The Coding Coordinator is responsible for the Coding department and reports directly to the Director of Revenue Cycle Operations. The Coordinator has the authority to plan, provide and participate in assigned projects or activities for the department, ensuring compliance with all federal and state regulations and registration documentation requirements; coordination of department work groups to ensure efficient workflow, compliance, process improvement and continuing education, and providing staff development and education to meet department standards and facilitate quality improvement.

Services Provided

The coding department focuses on minimizing the DNFB, preventing coding backlogs, minimizing compliance risk and maximizing accuracy rates. The coding department provides support to providers and other department's house wide to help ensure accurate compliant coding. The coding department applies all ICD10-CM, ICD10-PCS, CPT, HCPCS codes on all hospital accounts utilizing the 3M 360 Encoder. The coding department will query the provider participating in the care of the patient when a diagnosis or procedure has been determined to meet the guidelines for reporting but has not been clearly or completely stated within the medical record, when ambiguous or conflicting documentation is present The coding department provides support to patients with inquiry's related to the coding of their claim

Staffing Structure

The coding department is located in the Corrado Building on the third floor suite 320. Coding staff work remotely from home. Coding Coordinator located onsite in the Coding Department.

Coding is staffed between the hours of 4:00 AM and 6:00 PM

Director	1.0
Coordinator	1.0
Coding IP	7.0
Coding Observation	1.0
Coding ASU	3.0
Coding Emergency	10.0
Coding Series/Diagnostics	4.0

Key Departmental Relationships

Effective interaction between Patient Financial Services Medical Records and both clinical and ancillary departments is integral to fundamental department functions. Communication with clinical departments ensures both coding, charging, documentation compliance. Close interaction with Medical Records, Patient Access, Patient Financial Services improves workflow and reduces unnecessary claim delays. Case Management provides concurrent review, which effects reimbursement and support for Patient Advocacy Program. Ongoing relationship with Information Systems enables Coding to utilize multiple application software programs and hardware peripherals to manage workload and Coding functions.

Community Relations / Marketing:

Scope of Service

Mission and Purpose

The Department of Community Relations and Marketing consists of Community Relations, Communications, Marketing, and Healthy Ages After 50. These services support the mission, vision and values of Kadlec Regional Medical Center through marketing, customer service, education and communication.

The Community Relations, Communications and Marketing Department carries out the Marketing and Public Relations functions of the hospital, coordinating advertising, and communication and community outreach activities. This includes production of Community Health Journal TV program, advertising, public relations, publication of Pacesetter community newsletter, coordination of Safe Kids Saturday family safety fair, the Kadlec internet web page and other outreach activities.

Healthy Ages After 50 is a free senior health education program that serves approximately 10,000 members in the community. Each month, education programs are held covering an assortment of health topics. Also, seminars are held for members dealing with important issues such as Medicare billing and long-term care. The Healthy Ages coordinator also conducts age sensitivity classes for hospital staff and community service agencies.

Structure

Community Relations/Communications/Marketing	Budget $ 1,000,000 (approx.)	5 FTE
Healthy Ages After 50	Budget $ 120,000 (approx.)	1. 0FTE

Scope of Service

Community Relations/Marketing:

Offices located in the CBC Health Science Center, and operate weekdays between the hours of 8:30am and 5:00pm.

Healthy Ages After 50:

Department staff work out of offices located in the Kadlec Healthplex and operate weekdays between the hours of 8:30 am and 4:30 pm.

Communication

Periodic meetings are held with coordinators/specialists of the departments. All department staff undergoes annual staff development planning meetings with their supervisor. The departments communicate with employees and medical staff through a variety of means. These include e-mail, newsletter, memo, phone, and personal contact. The departments have key relationships with all departments of the medical center. All promote and support the mission of the medical center, and as such, have close working relationships with all hospital services.

Performance Improvement

Community Relations/Marketing:

- Media surveys conducted by local TV station
- Audience ratings of Community Health Journal TV program through Nielson ratings service four times per year
- Media placement of positive stories in area newspapers, TV and radio
- Calls to action through Community Health Journal TV program, Pacesetter Newsletter, newspaper advertising, and direct mail advertising
- Attendance at Safe Kids Saturday
- Kadlec On-Call Talk Radio
- Social Media

Healthy Ages After 50:

- Attendance at monthly education programs and screenings
- Amount of money billed to insurance through one-on-one counseling sessions with members
- Attendance at annual Medicare and Long Term Care Workshops
- Community and staff participation in Age Sensitivity training and other educational classes
- Enrollment of new members

COMPLIANCE & AUDIT:

Scope of Service

Please refer to the Providence Integrity and Compliance Program Description which is monitored on an ongoing basis and reviewed annually located at:

http://in.providence.org/sss/departments/compliance/Documents/Forms/AllItems.aspx?RootFolder=%2Fsss%2Fdepartments%2Fcompliance%2FDocuments%2FCompliance%20Program%20Description&FolderCTID=0x012000A3B951B8CD40EF4A81A6987664AD833F&View={9A437FCE-B7BC-4635-9CF4-58023484A4D6} .

Department Structure

Compliance and Audit is located on the fourth floor of the Columbia Basin College Health Science Center at 891 Northgate. The department is staffed from 8:00 am to 4:30 pm, Monday through Friday.

Staffing Structure

Current staffing is 1.0 FTE consisting of:

Compliance and Privacy Coordinator

Key Department Relationships

Compliance & Audit interacts with every department of the organization. Key relationships include departments which are at high risk for compliance related issues including: Accounting, Administration, Clinical Resource Management, Health Information Management, Information Systems, and Patient Financial Services.

Diabetes Learning Center:

Scope of Service

Mission and Purpose

The Diabetes Learning Program is a service of Kadlec Regional Medical Center staffed by a team of professionals dedicated to the continuous improvement of quality diabetes education and medical nutrition therapy that is respectful, compassionate and appropriate. The program strives to provide clients a timely service that is evidence based and outcomes driven to meet client education needs while maintaining national standards for quality diabetes care.

Goals:

1. Provide each client with quality diabetes education services, which are individualized, based on assessed needs, and that maximizes diabetes self-management skills.
2. Provide medical nutrition counseling services for a broad range of primary diagnoses with nutrition implications to maximize the nutrition status of the individual.
3. Provide services that meet the needs of the internal and external customers within the limitations of available resources.

Authority and Responsibility

The Manager, reports to the Director, Therapy Services, and the VP Professional Services and is responsible for the overall operation of the Diabetes Learning Center, inclusive of program development, implementation, development of department goals and objectives and employee development. Responsibility for process improvement and quality control activities, clinical practice, marketing, and basic daily operations are delegated to appropriate staff.

Department Structure

Description:

The Diabetes Learning Program is located at 1268 Lee Boulevard. It operates weekdays from 8:00 AM to 4:30 PM. Extended hours are offered on some days for late classes or appointments. Staff includes eleven certified diabetes educators (five registered nurses and five registered dietitians), and one registered dietitian.

Services Provided

The Diabetes Learning Program works with referring physicians to provide individualized comprehensive outpatient diabetes education services to children and adults with type 1, type 2, gestational diabetes or impaired glucose tolerance. Insulin pump training and management, and continuous glucose monitoring services are also available. Client needs are assessed and an individualized education plan is developed with client participation. Education services are delivered in one to one counseling or a group counseling setting as directed by the education plan. Referring physicians receive interim and discharge progress reports. A Type 2 Diabetes Support Group is offered monthly to any interested participant. A support group for Type 1 clients is offered quarterly.

As an affiliate site for the National Institute of Health's Trial-Net study, the Diabetes Learning Center provides screening and follow-up services to the Virginia Mason Benaroya Research Institute which coordinates the study for this area.

Outpatient Nutrition Counseling services are provided for a variety of primary diagnoses as well as for maintenance of good health. Medical nutrition therapy requires a physician referral. Self-referrals are accepted for normal nutrition education.

DLC educators provide Inpatient Diabetes Specialist services at Kadlec Regional Medical Center. An educator is on-call on weekends to assess insulin pump users who want to use their pumps while in the hospital and for newly diagnosed Type 1 children.

Standards

The Diabetes Education Program is recognized by the American Diabetes Association. The registered nurse maintains a current Washington state nursing license. The registered dietitian maintains current registration with the Academy of Nutrition and Dietetics, current certification with the State of Washington, a current Washington state Medical Assistant-Registered License, and is enrolled as a Provider for Medicare and Medicaid. All Certified Diabetes Educators maintain certification through the National Certification Board for Diabetes Educators, and all educators maintain a current CPR certificate.

Communications

DLC staff communicates frequently with physicians and hospital staff via phone, fax, written communication, and e-mail. Staff meetings and team meetings are conducted monthly to facilitate internal communication. An advisory committee meets one to two times a year to provide oversight and guidance to the diabetes education program.

Key Departmental Relationships

The DLC shares office space with Healthy Ages. DLC staff provides services to Cardiopulmonary Rehabilitation, Physical Medicine and Rehabilitation, Wound Care Therapy, Wellness, and Patient Care Services. The Clinical Nutrition Coordinator coordinates with the Inpatient Diabetes Specialist for diabetic teaching.

Performance Improvement

The DLC develops an annual performance improvement plan which includes performance indicators and performance improvement activities. This plan correlates with the annual program plan required for American Diabetes Association recognition.

DIAGNOSTIC IMAGING & CARDOVASCULAR SERVICES (DI & CVS):

Scope of Services

Mission and Purpose

Mission:

The Diagnostic Imaging and Cardiocascular Services departments (DI & CVS) provides diagnostic and therapeutic services in order to assist physicians in the provision of medical care to patients in need. DI & CVS provides these services with the highest regard to quality, effectiveness, safety, professionalism, compassion and care.

Purpose:

To provide safe, compassionate care to all patients requiring imaging or procedural support.

Authority and Responsibility

Administrative/Operational:

The imaging and Cardiovascular service lines are part of the Professional Services group. The Professional Services group reports to the Vice President of Professional Services of Professional Services. The Director of Diagnostic Imaging and Cardiovascular Services reports to the Vice President. The director is responsible for 24-hour operations of the department, program development and implementation of departmental goals and objectives. The director is also responsible for aligning department strategy with the overall Hospital strategy goals, and vision. In the unplanned or planned absence of the Director, overall departmental responsibility is delegated to the section Clinical Imaging Supervisors or Cardiac Services Technologist and Nurse Managers.

Medical Direction:

Columbia Basin Imaging, the contracted Rediology group provides medical direction for all Imaging services. The Chief of the Medical Staff per medical staff by-laws appoints these positions. In the absence of the Medical Director a Radiologist or Cardiologist is delegated the responsibilities of the position for the duration of the absence.

Nursing Services:

Nursing care is provided by qualified registered nurses (RN) under the administrative authority of the director and Medical Director. A qualified RN is assigned as lead nurse within the Imaging and Cardiovascular departments and is responsible for the coordination of daily nursing operations within their respective departments.

Department Structure

Facility Description and Services:

The Department of Diagnostic Imaging provides a broad spectrum of imaging modalities and services. The Department of Cardiovascular Services also provides a wide range of diagnostic and interventional procedures. Inpatientand outpatient hospital based imaging and cardiovascular services are provided 24 hours per day, 7 days per week. Those services include: Computed Tomography (CT), Radiology (fixed and portable radiography, and fluoroscopy), Angiography, Cardiac Catheterization, Interventional Special Procedures, Ultrasound, Echocardiography, Magnetic Resonance Imaging (MRI) and Nuclear Medicine. Outpatient based digital Mammography and DEXA services are available Monday through Friday at the Outpatient Imaging Center (OPIC) located at the 945 Goethals building.

CT – One GE LightSpeed helical scanner, Two 16 slice scanners and dressing rooms are provided to meet the needs of patients in regards to helical diagnostic CT, radiation therapy treatment planning and fine needle biopsy and aspiration. The CT department is staffed with ARRT certified, licensed and registered CT technologists.The department is also supported by registered nurses who provide appropriate nursing care and conscious sedation. Services and staffing for this section are provided for full services 24 hours per day, 7 days per week.

Radiology – The Radiology section consists of twofluoroscopic rooms, one computed radiographic room, one digital radiographic room, three digital and three non-digital mobile radiographic units and six mobile fluoroscopic units (C-arms) at the hospital. The OPIC has one fluoroscopic room, and two digital radiographic rooms. Dressing rooms are contained within the Imaging area and are shared available for patient use. Both Radiology sections are staffed by registered and licensed radiologic technologists. Registered nurses provide appropriate and specific nursing care when needed.

Angiography, Cardiac Cath, Electrophysiologyand Interventional Radiology procedures – Two digital Cardiac Cath, one Electrophysiology (EP), and one Interventional Radiology Procedure Suites are provided to meet the needs of patients in regards to cardiac catheterization and peripheral vascular intervention, pacemaker implantation, angiography and Interventional Radiology procedures. The Cardiovascular Services area also houses a film review room for providers and a patient holding area. A full range of physiological monitoring equipment is available to continuously monitor the patient in both the holding room and procedure rooms. The Cath Lab is staffed with registered, licensed and certified cardiovascular technologists and registered nurses who assist Radiologists and Cardiologists during procedures.

Ultrasound - The Ultrasound section encompasses four procedure rooms, each room containing digital abdominal and obstetric ultrasound equipment. A venous ultrasound system and mobile Abd/OB system are also provided. The Ultrasound section contains five exam rooms, two restrooms, and dressing and holding rooms. The section is staffed with registered sonographers (OB/Abd, or vascular). The Ultrasound section provides a full range of neonatal, perinatal and adult diagnostic services, that includes fine needle biopsy, cyst aspiration, paracentesis, and thoracentesis procedures. Registered nurses provide nursing care as needed.

Echocardiology – The Echocardiology section is located within the Cath Lab area and consists of two Ultrasound machines and one procedure room. The Echo section has three dressing rooms and one patient restroom. This area is staffed by four registered Echocardiology trained technologists. Registered nurses provide nursing care as needed.

MRI – The MRI section consists of one 3.0T and one 1.5T Open Bore systems at the hospital. The OPIC has one 1.5T one .7T Open system. Collectively, all provide a full compliment of MRI services. Both facilities include restrooms, dressing areas, patient holding and separate waiting room and reception areas. Both MRI sections are staffed with Registered and Certified MRI Technologists. Registered Nurses provide appropriate and specific care throughout.

Nuclear Medicine- The Nuclear Medicine section consists of one SPECT/CT camera, one dual-head camera, and one single-head portable camera in the hospital. The OPIC has one dual-head camera and one PET/CT unit. All units reside in distinct and separate areas and collectively provide a full range of diagnostic and therapeutic Nuclear Medicine services. Registered nurses provide nursing care when needed. Advanced Registered Nurse Practitioners (ARNP) provide oversight for complex testing when needed, such as cardiac stress tests.

Mammography andDEXA – This department is located in the Outpatient Imaging Center (OPIC). The mammography andDEXA departments consist of two GE digital mammography machines, one Hologic stereotactic breast biopsy table, one dedicated GE Logic S6 breast ultrasound machine, one Hologic Discovery QDR bone density machine, 8 dressing rooms, a dedicated waiting room, two bathrooms, two dedicated review workstations, one Rotoviewer for analog comparison images and one Kodak 8610 Laster Printer. The staff consists of ARRT Registered and Advanced Level Mammography technologists. Aregistered nurse serves as the breast biopsy coordinatorand provides nursing care as needed. The departments also employ a dedicated reporting system analyst and clerical support staff.

Staffing and Hours of Operation

The Diagnostic Imaging's Radiology and CT sections (hospital) provide service 24 hours a day, seven days a week in order to provide a scope of services consistent with the organozational needs. All other Diagnostic Imaging departments (MRI, Cardiac Catheterization Lab, Echocardiology, EKG, Ultrasound and Nuclear Medicine) are available twenty-four hours per day, seven days a week through a combination of on premises staffing during normal hours and "on call" staff availability after normal hours. Outpatient facilities are staffed during normal business hours Monday through Friday.

Staffing levels and normal hours of operation are determined by the Medical and Administrative Managers during the annual operations budgeting process or as needed. Diagnostic Imaging department services are available through utilizing the following minimum staffing levels and hours of operation:

Imaging Service	Hours Of Operation	Cardiac Services	Hours Of Operation
Radiology	Monday-Sunday 24 hour service	Cath Lab	Monday-Friday 0700-1900
MRI	Monday-Friday 0630-2300 Saturday 0700-1900	Echocardiology	Monday-Friday 0700-1730 Saturday-Sunday 0700-1900
CT Scan	Monday-Sunday 24 hour service	EKG	Monday-Sunday 24 hour service
Ultrasound	Monday-Sunday 24 hour service		
Nuclear Medicine	Monday-Friday 0630-1700		
Mammography	Monday-Friday 0700-1700		
DEXA	Monday-Friday0800-1400		
Director	Monday-Friday 0700-1630		
Radiologist	Monday-Friday 0700-2100		

Location:

Diagnostic Imaging has three locations within the first floor of the hospital and one outpatient center located across the street from the hospital campus.

Hospital First Floor:

1. Radiology, Ultrasound, Echocardiology, and Cardiac Cath are located in the South side of the building between the two lobby areas. Management and Radiologist offices are located in this area.
2. Nuclear Medicine is located next to the Laboratory.
3. MRI is located next to Radiology and Cardiac Services.
4. Long-term film storage is located in an offsite location at 1100 Jadwin.
5. CT Scanner is near Emergency Room Area.
6. Digital Radiology (DR) is near Emergency Room Area.

Outpatient Imaging Clinic:

Radiology, Mammography, DEXA, MRI, Nuclear Medicine, Ultrasound, and CT outpatient procedures are provided on the first floor of the Richland Medical Building, which is located at 945 Goethals Street, across the street (Swift) from the hospital campus. Ultrasound is also offered on second floor for the APW physicians. There are currently three rooms in this area.

Key Departmental Interactions

Diagnostic Imaging has interaction with all Departments in the hospital. Our key departmental relationshipsare with Perioperative Services, Operating Room, Emergency Department, Acute Care Units, Neonatal Intensive Care Unit, Intensive Care Unit and Critical Care Unit. Our goal in these relationships is to provide diagnostic and therapeutic support as part of the continuum of care for the patient.

Departmental Quality Control

The following indicators are monitored continuously and reported at least quarterly through the departmental staff meetings and Rad/Path Committee:

- PACS Verification
- Digital Quality Control
- Unexpected Occurrences Including (QRR):
- Contrast Reactions
  Re-Scheduled Procedures
  Quality Concerns
- Patient Communications (Compliments and Complaints) QRR
- Radiation Safety Including:
- Radiation Film Badge Reports
  Protective Devices Survey
- Patient Site Verification
- Verification of Procedural Time Out
- ED/Imaging Patient Procedure Times
- Critical Results
- Hand Hygiene
- Access
- Dropped Calls
- Staffing Model Reviews

Physicians' Peer Review

The following indicators are monitored monthly and reviewed quarterly at the Radiology Medical Staff Committee:

- Interesting Cases (Peer Review)
- Addendum Reports Analysis

Departmental Strategic Quality Leadership (SQL)

The following SQL 2008 initiatives are in progress within Diagnostic Imaging and Cardiovascular Services:

- Strategic Business Planning
- ED/DI Cycle Team
- Automated Telephone Call Distribution
- Staffing vs. Call Backs
- Survey Implementation and Analysis (OPIC)

EDUCATION DEPARTMENT:

Scope of Service

Mission and Purpose

Mission:

The Education Department provides and coordinates learning opportunities for Kadlec Regional Medical Center staff, physicians, volunteers, and the community, which support the organizational goals.

Purpose:

1. Identify organizational learning needs.
2. Plan and provide on-going educational opportunities, which fulfill identified learning needs and facilitate staff development.
3. Assure excellence in service and support to all Education Department customers.
4. Develop and facilitate an organizational environment that fosters and rewards learning.

Authority and Responsibility

The Director of Education reports to the Vice President of Support Services, and is responsible for the overall operation of the Education department, Volunteer Services, Academic Services, inclusive of program development and implementation of department goals and objectives. In the absence of the director, overall department responsibility is delegated to the Safety Education/Orientation Coordinator.

Department Structure

The Education Department is located on the second floor of the Mountain Pavilion. Hours of operation are Monday through Friday, 8:00 AM to 4:30 PM.

Services Provided

The Education Department provides services and support to all departments and affiliated service providers of Kadlec Regional Medical Center. Services include:

- New Hire Orientation
- Safety Education (New Hires, Volunteers, Students, and Annual Safety programs)
- Volunteer Orientation
- Nursing Orientation
- Student Orientation
- Resuscitation Education
- Content Management of Policies & Procedures
- Leadership Training
- Computer Use Training
- Coordination of continuing education credits (CME, CNE)
- Coordination of Physician Education Committee
- Documentation of attendance to programs provided through the Education Department
- Coordination and training of medical library and electronic library services
- Coordination of Computer Based Training (HES)
- Coordination of Volunteer Activities and Orientation
- Coordination of relationship with student programs (WSU, CBC, U of W, etc.)
- Coordination of the Richland and Hanford High School Intern program
- Coordination of allied health student and agency internships
- Coordination of Community Education classes
- Coordination of meeting room resources and AV equipment

Staffing Structure

Education Director (1.0 FTE)

Safety Education/Orientation Coordinator, RN (1.0 FTE)

Volunteer Coordinator (1.0 FTE)

Clinical Education Coordinator (1.0 FTE)Physician Education Coordinator (1.0 FTE)

Content Management Specialist (1.0 FTE)

Learning Management System Specialist (1.0 FTE)

Office Assistants (6 FTE)

Student Services Specialist (1.0 FTE)

TC Coordinator (1.0 FTE)

Resuscitation Class Instructors (1.0 FTE)

Community Education Instructors (0.8 FTE)

Clinical Education Instructor, RN (0.2 FTE)

Standards

RN Licensure is verified through the Staffing Office.

Resuscitation Instructors are certified through the American Heart Association.

Prepared Childbirth Instructors are RNs or certified through ICEA or CAPPA.

Key Departmental Relationships

- Volunteers
- Human Resources
- Information Systems
- Environmental Services
- Marketing
- Accounting
- Nutrition Services
- Medical Staff Services
- CIS
- Department Clinical Educators
- Department Directors, Managers, Coordinators, Supervisors

EMERGENCY DEPARTMENT:

Scope of Service

Mission and Purpose

Mission:

The Department is committed to timely evaluations, stabilization, definitive treatment and/or transfer to a higher level of care. The Emergency Department physician in consultation with various specialists determines treatment needs and/or transfer needs. (This could include the need for Pediatric ICU capabilities, burn care, management of complicated trauma patients and major organ transplants). The Department is also committed to appropriate referral for treatment and follow-up care as needed; and the provision of patient centered care according to departmental standards.

Purpose:

The Emergency Department is a quality driven integrated emergency care system, benefiting all segments of the community, providing the highest level of care and customer service.

Department vision will be achieved by fulfilling the following goals:

- To be customer driven
- To participate in improving the health of the community
- To be an excellent place to work & practice.
- To be cost competitive and financially viable
- To provide the highest quality of emergency patient care
- To invest in our future
- To partner with our physicians to provide excellent care.

Authority and Responsibility

The Clinical Coordinator reports directly to the Nurse Manager, the Nurse Manager reports directly to the Vice President of Nursing. In the absence of the VP of Nursing, overall department responsibility is delegated to the Nurse Manager and/or the director covering for the VP of Nursing.

The Nurse Manager is responsible for the 24-hour operations of the department, program development, and implementation of department goals and monitoring outcomes. In the absence of the Nurse Manager, the Clinical Coordinator would carry out these operations.

The designated Medical Director is responsible for providing certain administrative services such as facilitating communication between KRMC management and physicians, coordinating continuing education programs by physicians for ED staff, reviewing treatment modalities and assessing practice patterns as well as monitor trends and outcomes. The Medical Director consults with Kadlec's President/President/Chief Executive Officer of Kadlec Health System.

Department Structure

The Emergency Department consists of 37 private patient care rooms: 20 beds in the Red and Blue Zones,11 beds in the Yellow Zone and 6 beds in Fast Track/Intake. The Emergency Department is easily accessible to the public with well-defined illuminated signage approaching the Medical Center as well as located in multiple areas inside the Medical Center. There is street access for ambulances as well as a helipad located on top of the Vineyard Pavilion (3rd Floor) and River Pavilion (11th floor) buildings for air transports. Additionally there is a ground helipad available as back-up. For walk-in ED patients, use of Valet parking is available or the entrance is located adjacent to the patient parking lot and signed appropriately.

Services Provided

The Emergency Department, as part of Kadlec Regional Medical Center, which is a community-based medical center, consists of a team of professionals dedicated to the continuous improvement of quality care that is respectful, compassionate, and appropriate. The Emergency Department provides emergency care to patients of all ages (neonate to geriatric), and socioeconomic levels, regardless of ability to pay. Service is provided 24 hours a day, 7 days a week, 365 days a year. The ED at KRMC offers comprehensive emergency medical service including adult and pediatric code teams, septic shock teams and is a Level III designated Trauma Center, Level II designated Stroke Center, and a Level I Cardiac Center.

Patients will be triaged according to the Emergency Severity Index (ESI) and as outlined by standards set forth by the Emergency Nurses Association, and documented in the patient's electronic health record.

Acute Triage Level	ESI Acuity Level	Reassessment
• Critical	Level 1	Continuous
• Emergent	Level 2	Every 30 minutes
• Urgent	Level 3	Every 60 minutes
• Semi-Urgent	Level 4	Every 120 minutes
• Non-Urgent	Level 5	Every 120 minutes

During any part of the triage assessment, if the nurse or physician determine that the patient has an emergent condition, the triage assessment is interrupted and appropriate interventions initiated. If the patient is in the waiting room, the Quick Look nurse will reassess patients at least every 60 minutes with chart documentation. Re-categorization, or re-triage will be performed whenever new information arrives or a change in patient status occurs.

All staff is responsible in identifying educational needs for the patient based on the triage assessment and treatment course identified during the patient's visit. Social services is available in the department Monday – Friday for 12 hours, during other times, the PCC can be contacted to help facilitate appropriate resources including other community referrals. The ED Physicians and Mid-Level Providers are responsible for generating the patient's electronic discharge instructions, care notes and prescriptions at time of disposition.

Staffing Structure

The department has 24-hour coverage by Board Certified Emergency Physicians, and/or Mid-Level providers consisting of Nurse Practitioners and Physician Assistants, and Scribes They are a contracted group with Northwest

Emergency Physicians, a division of Team Health. In addition, the department has RNs, Emergency Department Technicians and Unit Secretaries. The department also includes a Trauma Coordinator, Clinical Coordinator and a Clinical Educator as part of the professional team.

- Unit Manager: Current WA State nursing licensure. BSN from an accredited program with a minimum of 3 years recent experience in an emergency department. Previous management experience preferred. Ensures quality patient care by establishing and maintaining clinical standards of practice and care while meeting unit staffing requirements.
- Clinical Coordinator: Current WA State nursing licensure. BSN or Bachelor's in a business related field or a Masters Degree in a related healthcare field, Minimum of two (2) years recent experience in related area or management experience in an acute care setting.
- Clinical Educator: Current WA State nursing licensure. BSN from an accredited program with minimum of 3 years experience in an emergency department. Demonstrates clinical competence and in-depth knowledge in an emergency department setting. Demonstrates effective teaching and communication skills.
- Trauma Coordinator: Current WA State nursing licensure; CPR, ALLS, TNCC, ENPC, CEN preferred. BSN from an accredited program with a minimum of five years recent clinical experience in an ED with at least Level III trauma designation.
- RNs: Current WA State nursing licensure. CPR, ACLS contingency of hire, PALS/ENPC and TNCC certification required within 6 months of hire. CEN encouraged.
- Emergency Department Technicians: Current HCA certification for the State of Washington, CPR certification, recent experience in an ED, pre-hospital or critical care setting encouraged, on the job training provided.

Staffing is based on patient volumes and arrival times and how they impact standards of emergency nursing care.

Staffing patterns will be analyzed and reviewed annually as part of the annual budget review process. Consideration will be given to findings from quality assessment and improvement activities.

The staffing standards are as follows 7 days a week

ED Nursing Staff (Includes Charge Nurse)

Time	Standard
0700 – 0900	7
0900 – 1100 1000 - 1100	9 11
1100 – 1200	13
1200 – 1300	14
1300 – 1400	15
1400 – 1500 1500-1900	16 17
2100 – 2300	13
2300 – 0000	13
0000 – 0100	11
0100 – 0200	10
0100 – 0200 0200-0300 0300-0700	9 8 7

Emergency Department Technicians (EDT's)	Standard
Time	**Standard**
0700 – 0900	2
0900 – 1100	3
1100 – 1400	5
1400 – 2100	6
2100 – 2300	5
2300 – 0200	3
0200 – 0600	2

All efforts will be taken to accept patients requiring admission to Kadlec Regional Medical Center. A Code Purple will be activated when all options to facilitate patient flow have been exhausted. A Code Purple occurs during a combination of high patient census or overcrowding, high volume of patients presenting to the emergency room, multiple post-op surgical patients to place and all staffed hospital beds are occupied by patients. Nursing leadership will work to facilitate efficient and effective patient flow to ensure every effort is made to accept all patients requiring admission into Kadlec Regional Medical Center, (Consider ED Overcrowding Policy (24.18.01) and the Code Purple Policy (634.00)

Key Departmental Relationships

The Emergency Department is committed to the provision of patient centered care that is customer service driven. Our goal is to provide excellent care and patient satisfaction, meaning efficient throughput or patient flow is critical for getting patient disposition in a timely fashion. The ED works collaboratively with, but not limited to, the following departments to ensure that processes are evaluated and improvement opportunities identified that affect the throughput.

- Diagnostic Imaging
- Laboratory
- Respiratory Therapy
- Cardiac Services
- Nursing Services
- Perioperative Services
- Transfer Center
- Consultants and Hospitalists
- **Finance**
- FinanceDirector of FinanceSenior Director ofDirector of FinanceDirector of Finance.
- Finance at503 Knight Street in Richland, Washington Finance
- Finance
-

Director of Finance	
Sr. Financial Analyst	3.0
Accounting Analyst	

- Director of Finance, and Sr. Financial Analyst
- Finance

GENETIC COUNSELING:

Scope of Service

Mission and Purpose

Mission:

The genetic counselor works as a member of the medical team providing accurate and comprehensive genetic counseling to clients and their families. Genetic counseling assists patients in making informed decisions about their health and wellness. Genetic counselors support clients in making complicated healthcare choices.

Authority and Responsibility

- The genetic counselor reports to the Director Rehab and Allied Health who reports to the VP of Nursing
- The genetic counselor also works with the assigned medical director

The genetic counselor is responsible for providing accurate and comprehensive genetic counseling to preconception, prenatal, pediatric and adult clients. The genetic counseling appointments should include a review of medical records, research, obtaining accurate pedigrees and medical histories, risk assessment, explanation of genetic conditions, review of testing options, decision support, reporting and explaining results, follow up care and referrals when indicated. The genetic counselor will send a detailed consultation note to the referring provider.

The genetic counselor will stay current with medical genetics and genetic technology in order to provide clients with accurate information about genetic disorders and birth defects. The genetic counselor is responsible for continuing education by reviewing medical journals and literature related to medical genetics. In addition the genetic counselor should attend at least one major medical genetics conference per year to maintain the National Society of Genetic Counselors Certification.

Department Structure

- The Genetic Counseling office is located on the 2nd floor of 945 Goethals Drive
- The Genetic Counseling office hours are 8:00 am to 4:30 pm. These hours are flexible as complex cases and high caseloads may require extended hours

Services Provided

- Genetic counseling is a consultative service
- Services are available for preconception, prenatal, pediatric and adult clients
- Provide education about genetic risk, testing options, decision-making
- Evaluate family and medical history, assess risk, and discuss options using the most current information available
- Discuss the pros and cons of testing and assist in interpretation of complex testing results
- Genetic counselors provide supportive counseling to patients and families during and after the testing process

Staffing Structure

- Current staffing is 1.5 FTE comprised of the part-time genetic counselor and a full time Front Office Assistant
- Genetic counselor reports Kadlec Clinic Practice Administrator

Standards

- The genetic counselor must have a master degree from an ABGC accredited university
- The genetic counselor must be ABCG board certified or board eligible
- The medical director must be a licensed physician in Washington State however board certification in medical genetics is not required

Key Department Relationships

- The genetic counselor will work with both inpatient and outpatient referral
- The genetic counselor interacts with most departments within the medical center as well as a variety of medical specialties

HEALTH INFORMATION MANAGEMENT:

Mission and Purpose

Health Information Management staff collect, process and deliver private health information in compliance with state and federal regulations ensuring accurate, compliant and accessible health records for all patients of Kadlec Health Systems. The department works to continuously improve workflows and services, ensuring the staff are performing the highest level of customer services in a professional manner with integrity and respect.

Authority and Responsibility

The Health Information Manager is responsible for the entire Health Information department and reports directly to the Director of Revenue Cycle Operations. The Manager has the authority to plan, provide and participate in the assigned projects or activities for the HIM department, ensuring compliance with all federal and state regulations and documentation requirements: coordination of department work groups to ensure efficient workflow, compliance, process improvement and continuing education, and providing staff development and education to meet department standards and facilitate quality improvement.

The following caregivers report directly to the Manager of Health Information Management:

- Coordinator, HIM (Data Integrity)
- Supervisor, Document Capture
- Supervisor, Release of Information
- Analyst, HIM (Transcription/Dragon Services)

Services Provided

The Health Information Management Department maintains individual patient (specific) records and statistical (aggregate) health information for patients, health care providers, the hospital and other authorized users to provide information for continuity and improvement of patient care in the region.

Customer support services are provided to patients and clinicians across the organization, which includes My K-Chart, Dragon and Transcription services. Customers are provided assistance and training on access, use of these systems, documentation requirements and correction of charting errors. HIM offers support for providers and outreach to community clinics and providers to encourage greater use of the electronic health record.

Various services are provided by responsible teams:

- **Document Capture Team** – collects, prepares and scans all paper documents into the patient record. The Document Capture Team provides consistent processing of records received in paper format as well as electronic format from both the hospital campus and all Kadlec Clinic locations.
- **Release of Information Team** – releases records per state and federal guidelines, in compliance with HIPAA and HITECH. The ROI Team ensures quick turnaround of requested records and maintains current knowledge of legal access of the medical record.
- **Data Integrity Team –** analyzes patient records to ensure completeness, accuracy and compliance. Coordinates and performs chart corrections and patient merges to maintain an accurate Master Patient Index.
- **Dragon/Transcription Team** – trains all users and provides at-elbow support for providers and end-users of Dragon and Transcription services.

Staffing Structure

- Primary work in the HIM department is performed Monday through Friday, 7:00 a.m. to 8:00 p.m.
- The Release of Information group provides full services during the department's primary hours, with limited services Saturday and Sunday, 7:00 a.m. to 8:00 p.m.
- The Document Capture group provides full services during the department's primary hours, with limited services Saturday and Sunday, 7:00 a.m. to 4:30 p.m.
- Dictation support services are provided 7 days a week, primarily 8:00 a.m. to 5:00 p.m., with after-hours support provided as needed when notified by the IT Help Desk

Health Information Management Staffing Structure	FTEs
Director (under Revenue Cycle)	1.0
Manager	1.0
Coordinator	1.0
Supervisor(s)	2.0
HIM Analysts	4.0
HIM Specialists	4.0

HIM Technologists	23.5
Per Diem HIM Techs – 11	0.0
Medical Language Specialists (Transcription – Pay Plus Benefits)	10.0

Locations

The HIM Department is located at 1270 Lee Boulevard, Richland, WA. The Transcription/Dragon Support employees are located in the Mountain Pavilion room #P2040. The ROI satellite office is located in the main Campus, near the Gift Shop. Most archival is maintained in the HPF system or microfilm housed at the main office. Microfilms, fetal monitor strips, and some Kadlec Clinic records are stored at Records Management Services

Standards

Health information standards are established according to accepted HIM principles. The department complies with federal and state regulations established by the Centers of Medicare/Medicaid, Washington State Legislature, and Code of Federal Regulations. Additionally, HIM maintains task specific standards for performance volumes and accuracy as defined in departmental policies and procedures, in compliance with CMS, HIPAA and HITECH.

Key Departmental Relationships

Effective interaction between Health Information Management and both clinical and ancillary departments is integral to fundamental department functions. Communication with clinical departments ensures both accuracy of scanning and indexing documents into the patient medical records and compliance with all regulatory guidelines. Effective communication also assists with timely release of patient medical records to patients, outside medical facilities and any other requesting parties. Close interaction with Coding and PFS improves workflow and reduces turnaround time for claims. Ongoing relationship with IT enables HIM to utilize multiple application software programs and hardware peripherals to manage workload and daily tasks.

HUMAN RESOURCES:

Scope of Service

Mission

Human Resources' primary responsibility is to develop and align HR strategies with business needs while ensuring the recruitment and retention of competent caregivers. In support of this mission it provides solutions to complex or critical workforce issues, consultation on efforts to achieve outcomes and recommends actions. It administrators brokered services for employee / labor relations, compensation, benefits, employee and occupational health, employee development and recruitment. It collaborates with the Education Department to ensure employees and volunteers are oriented, trained and assessed for their on-going competency.

Department Structure

The **Director, Human Resources** has overall responsibility for Human Resources for the Health System. They lead the HR team in the development and alignment of HR strategies consistent with business needs. The Director has oversight of the Human Resources Standard for The Joint Commission and ensures compliance in regulatory matters through delegation of department tasks and collaboration with key departments/positions. Reporting to the Director are the HR Client Managers, HR Partners, and HR Associate. A dotted line reporting relationship also exists for the Manager, Talent and HRIS Analyst and Bright Horizons (Kadlec Childcare Center).

The **Manager, Talent – Recruitment** has the primary responsibility of overseeing overall recruitment practices/strategies for the Medical Center. Manager, Talent also partners with the Recruiters or directly recruits hard to recruit positions to ensure effective and timely recruitment of such positions. Reporting to the Manager are the Recruiters; the Talent Acquisition Coordinators; and a dotted line reporting relationship with the Preboarding Specialist.

Recruiters (4) have primary responsibility for the recruitment of all staff and management positions throughout Kadlec including staff nurses, ancillary professionals and management positions.

The **HR Client Managers and HR Partners acts as the primary point of contact for caregivers and core leaders for HR and employment related matters. They understand the alignment of HR strategies and business needs and implement initiatives in support of strategies. They serve as trusted advisors and advocates for caregivers and core leaders and facilitates resolution for HR related concerns.** The

The **HR Associate performs a wide range of transactional duties in support of new caregiver onboarding and orientation, other HR related caregiver activities, and investigating and triaging caregiver questions/ concerns and prepares a variety of HR reports.**

The **HRIS Analyst and HR Assistant/HRIS Administrator are** responsible for our Human Resource Information System and the development of its capabilities.

The Employee Health Nurses are responsible for all pre-employment screening; ongoing annual employee testing; employee health campaigns (i.e. Influenza/Tdap); and monitoring of post exposures. The Employee Health Nurses are also responsible for Workers' Compensation management and oversight of the Transitional Duty program.

The Administrative Assistant provides administrative support for the Director, Human Resources and general support to Manager, Talent and the Human Resources office. The Administrative Assistant also provides oversight and mentoring to the HR Administrative Float Pool.

Location/Hours of Operation:

The Human Resources (HR) Department is located in the CBC Health Sciences Center on 891 Northgate. Hours of operation are Monday through Friday, 8:00am to 4:30pm

Staffing

The department schedules to ensure a knowledgeable HR staff person is available during scheduled hours of operation. The Director is available as needed either at the main hospital location or via cell phone.

Services Provided

The HR Department has a broad range of regulatory and compliance responsibilities related to the employment. The primary areas of responsibility are:

Employment:

Licensure

Criminal Disclosure

WATCH Report

Report Sanctioned Individuals and/or National Practitioner Data Bank query

Immigration Control Act (I-9)

Reporting employment to DSHS

WSHRC, EEOC (ADA, ADEA, Title VII, EEO-1, DOL)

Labor Relations:

NLRB

Benefits:

ERISA

FMLA, WFLA, WFCA

Compensation:

FLSA

IRS

WA. Department of Labor, Wage & Hour

Workplace Safety:

WISHHA (OSHA 300)

Department of Health regulations

Labor & Industries (Worker Compensation)

In addition to the regulatory and compliance activities, HR administers the following contracts and programs:

WSNA Collective Bargaining Agreement

Tuition Assistance Program

Traveler and Temporary Staffing Recruitment and qualification

FlexChoice Benefit Plans

Unemployment Insurance Program

Workers Compensation Program

Retirement Plan

Employee Assistance Program

Temporary Clerical Pool

Wage and Salary Administration Policy

Quality Controls

Human Resources monitors for employee development, criminal disclosure, "sanctioned status", annual enrollment in FlexChoice, waiver completion, and W-4 enrollment.

Benchmarks

Human Resources participates in wage and benefits surveys to benchmark our competitive position.

Infection Control

INFECTION PREVENTION:

Scope of Service

Mission and Purpose

The Infection Prevention program is designed to implement surveillance, prevention and control strategies that will reduce the risk of endemic and epidemic infections in the patients, visitors and staff of Kadlec Regional Medical Center.

Structure

Infection Prevention is organized as part ofResource Team. The Infection Control practitioner works under the direction of the Nursing Admin Director.

Scope of Service

Surveillance for nosocomial and community acquired infections in patients and staff. Identification of trends including but not limited to:

Nosocomial infections

Community acquired infections

Resistant organisms

Use of Standard Precautions and transmission-based precautions

Sources for information used in surveillance include:

Daily lab reports	Information from Public Health and Centers for Disease Control
Unit rounds	Information from Physicians
Periodicals, Journals and research papers	Referrals from nursing staff and microbiology staff
Daily admission and re-admission reports	MedMined Data

Programs used in development and analyses of data include:

Excel	CIS Computer Systems
Med	Mined DataT-System

IP Practitioner is member of various hospital committees including;

P&T	Emergency Preparedness
Safety Committee	Patient Care Services
Value Management	CRA Committees
Education Council	Patient Safety
Infection Control Committee	

The Infection Prevention Practitioner is a Registered Nurse or Med tech with additional specialized training and Certification in Infection Control and Epidemiology. The position is exempt.

Policies are developed using standards set forth by CDC, APIC, OSHA, TJC and other recognized professional and regulatory agencies.

Communications

The Infection Prevention Practitioners communicate surveillance data to physicians, patient care staff through the Infection Control committee, physician and staff meetings, safety huddle, Board QI reports, Administrative Reports, Safety Committee, , Patient Safety Committee, direct staff interaction and consultation, and other hospital committees as required.

The Infection Prevention Practitioners are involved in house-wide education through New Employee Orientation, Competency Fairs and other educational presentations as needed. The Infection Prevention Practitioner is also an active member of construction planning and evaluation. The Infection Prevention Practitioners maintain current practice information through attendance at local educational offerings, system level offerings and national level educational offerings by APIC, SHEA and others.

Departmental Structure

Infection Prevention is located in the Corrado Building, Suite 370.

IP Practitioner 4.0 FTE

Information Services Organization:

Scope of Service

Mission and Purpose

Mission:

Information Services Organization is a high performing group of skilled individuals in software/hardware technology, applications, implementation, data analytics, provisioning and other technology services dedicated to serve patients, caregivers and all that we serve in the community.

Purpose:

- Provide a portfolio of highly functional, enjoyable to use information systems that meets the needs of all those we serve
- Make information accessible when and where it is needed to provide patient centered healthcare based on best practices
- Deliver great service through highly reliability, easy to access and competent service oriented team
- Provide systems at an affordable price point
- Provision information services to our community partner organizations
- .

Authority and Responsibility

The strategy and vision is developed at the system level and is represented and supported at the local level by the Director, Customer Services and Relationsip Management (IS Strategic Partner) The Director. CSRM (IS Strategic Partner) is responsible for the relationship management between the System IS and the Region to ensure that IS services strive to meet the unique needs of customers. The incumbent will work on the following strategies:

- Develops and implements appropriate service delivery models for core functionalities where System IS is a trusted adviser in defining, delivering and improvement services for the enterprise and its customers.
- Builds relationships with operational leadership to effectively represent and prioritize its needs to peers in System IS to ensure effective innovation.
- Enables an effective conduit of ministry or business unit-level requirements to the and PH&S Information Strategic Steering Committees and System IS operational divisions to ensure that local needs are met on an on-going basis
- Advocates for overarching IS strategies and standards, effective resource utilization and system-wide capabilities to ensure patients in have a consistent and excellent PH&S experience.
- Additionally the Director, CSRM has delegated authority to lead the Clinical Engineering Department. The CE team evaluates, installs and maintains all medical equipment used within the hospital, whether the equipment is hospital owned, leased, rented or physician supplied. The CE Team maintains an up to date inventory of medical equipment and performs preventive maintenance and inspection based on written risk.

Organization Structure

Hours of Operations:

- Primary work is performed Monday through Friday, 8:00 a.m. to 4:30 p.m.
- The IS Help Desk provides a tiered level of support 24x7x365 based on the urgency of the requests. Customer's expectations are met through well-defined Service Level Agreements. The ISHelp Desk can be reached at 943 – HELP (4357)

Locations:

The Information Services team is part of the Providence Shared Services and has major locations in Renton, WA, Portland OR. Additionally members of the IS Team are located at each location and they may provide services specific to that location or to the entire System. At Kadlec, the IS Team is located at 1270 Lee Boulevard, Richland, WA. The Clinical Engineering Team is located in the Main Hospital, on the 1st floor Mountain Pavilion.

Budget: The Operating and Capital budget for the Information Services team is developed centrally with input from every service area. The Operating and Capital budget for the Clinical Engineering Team is team is developed at Kadlec level with input from various clinical areas.

Organization

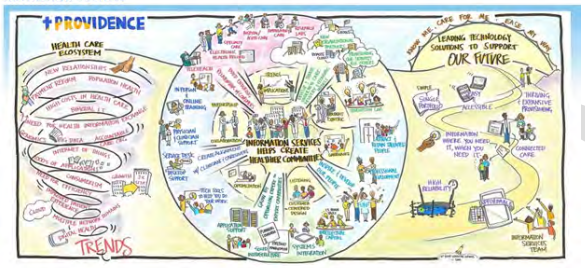
The Information Services Organization is a shared services organization. The local representatives are:

- Director, CSRM (IS Strategic Partner)
- Chief Medical Informatics Officer
- Senior Clinical Informatics Manager
- End User Support Supervisor

Services Provided

The services provided by Information Services are summarized on the image shown below

Information Services



Communication:

Day to day communications occur via discussions at meetings, telephone calls, email, web pages and face to face communications with staff across the organization. IS staff serves on several teams and committees in order to provide input and assist with decision making for patient care documentation that impact patients, providers, technology and the organization.

IS staff participates in Safety Committee, Emergency Preparedness Committee, and Employee Relations Committee., multidisciplinary work groups and committees as assigned.

Key Customers for Information Services

- Kadlec's Clinical and non-Clinical Departments including Diagnostic Imaging/Outpatient Imaging Center, and Laboratory.
- Outside Services: Tri-City Regional Surgery Center, Leslie Gage Clinic, Cancer Center, Kadlec Clinics, Kadlec Neuroscience Center, Diabetes Learning Center, Health Science Center, Physician Offices, Prosser Memorial Hospital, various healthcare organizations services by Clinical Engineering Team.
- Patients using myK-Chart portal and providers using the Physician Portal.

Performance Improvement

Major quality and service indicators that are measured:

- Applications and Systems Availability/Reliability
- Customer Satisfaction
- Percentage of incidents resolved by the Help Desk or first level
- Average time to resolve the work order per incident
- Percentage of active reopened problem tickets
- Resolution time with respect to Service Level Agreement (SLA)

INPATIENT REHABILITATION:

Scope of Service

Mission and Purpose

The Inpatient Rehabilitation Unit (IPR) provides quality, multi-disciplinary care in an acute setting. IPR consists of a team of professionals and support staff that are dedicated to individualized care and the restoration of function to the highest level of independence for each person.

Authority and Responsibility

Under the general direction of the Vice President of Professional Services, the Director of Therapy Services, implements, assesses and evaluates the timely and appropriate delivery of patient care, and collaborates with appropriate medical staff for the overall planning of patient care across the care continuum. He/she participates in the development of standards of patient care and standards of practice, consistent with current research and nationally recognize profession standards, ensuring standards are being met; participates in the Medical Center planning that considers community health needs and results in development of strategic initiatives supporting the mission and vision; develops annual capital and operational budgets and education calendars to operationalize those initiatives; and supports and demonstrates the mission, vision and values of Kadlec Regional Medical Center.

Under the general direction of the Directors, the Manager of Therapy Services and Rehab Supervisor is responsible for the day-to-day operation of the unit. They ensure quality patient care by establishing and maintaining clinical standards of practice and care while meeting unit staffing requirements. They perform all aspects of human resource management, including interviewing, hiring, and counseling; and will assess, plan and evaluate the unit orientation and education requirements and assure that they are met. They are responsible for participating in developing the annual budget preparation including operational and capital items; assures that hospital policies and procedures are updated; and participates and coordinates unit and organizational quality improvement activities. They intervene in patient, family and physician issues in a timely manner; and supports and demonstrates the mission, vision and values of Kadlec Regional Medical Center.

The Medical Director for IPR is responsible for medical standards and direction in IPR, and participates in administrative functions such as performance improvement as well. This is a contracted position with the medical center.

Department Structure

Description:

The unit is located on the third floor of building. The 20-bed unit operates 24 hours a day, 7 days a week. The unit serves stroke, spinal cord, and orthopedic injured and debilitated patients. There is an open multi-purpose room adjacent to the nursing station to promote interaction between the staff and patients. The gym is located on the first floor.

Organizational Structure

Director / Manager / Clinical Educator

Days		**Nights**	
Skill	FTE	Skill	FTE
Lead RN	1.0	Lead RN	1.0
RN/LPN	1.0	RN/LPN	1.0
NRT/CAN	1.0	NRT/CAN	1.0

Staffing is adjusted based on the needs of the patients, as outlined in department policy.

Services Provided

IPR provides 24-hour nursing care to adult patients by RNs and CNAs. The unit is CARF accredited. Typical patients include orthopedic, neuro, and stroke diagnoses.

Clinical therapy and social work services as well as other support services are provided based on their scope of service.

INPATIENT WOUND AND OSTOMY CARE:

Scope of Service

Mission and Purpose

The Inpatient Wound and Ostomy Care department provides wound care consultation to inpatients and ostomy consultation to inpatients and outpatients.

Goals and Services

The goal is to reduce the incidence of patients who develop pressure ulcers, provide optimal management of patients with wounds and ostomies and to provide education to patients, families, nursing staff and physicians about preventive measures and techniques to optimize wound healing and manage ostomies.

Authority and Responsibility

The Lead Wound Care Nurse reports to the Supervisor of Inpatient Rehab and has delegated authority to participate in the assigned activities of the department and is responsible for program development and implementation of department goals and objectives. In the planned absence of the Manager, overall department responsibility is reverted to the appropriate designee.

The day-to-day operations are the responsibility of the Lead Nurse for Wound Care.

Department Structure

Location: The Inpatient Wound and Ostomy Care department is located on the second floor within the Clinical Resource Management area in the Mountain Pavilion.

Hours of Operations

A wound care nurse is on duty daily from 0800-1830.

Staffing and Structure

Manager1

Registered Nurses2.5

Key Customers

Patients

Nursing Staff

Physicians

Communication

Day-to-day communication occurs via email, telephone, face-to-face, meetings, and written memos/information. Wound care nurses participate on hospital-wide committees.

INTENSIVE CARE SERVICES:

Scope of Service

Mission and Purpose

Intensive Care's priority is to provide quality, cost-effective care to our community and surrounding areas. We work together as a team to improve health and the quality of life during all phases of the critical illness process.

Authority and Responsibility

Under the general direction of the Vice President of Nursing, the Unit Manager directs, implements, assesses and evaluates the timely and appropriate delivery of patient care. Collaborates with appropriate medical staff for the overall planning of patient care across the care continuum. Participates in the development of nursing standards consistent with current nursing research and nationally recognized professional standards; ensures standards are being met. Participates in the Medical Center planning that considers community health needs and results in development of strategic initiatives supporting the mission and vision.

Under the general direction of the Vice President of Nursing, the Unit Manager is responsible for the day to day operation of the nursing unit. The Unit Manager ensures quality patient care by establishing and maintaining clinical standards of practice and care while meeting unit staffing requirements. The Unit Manager performs all aspects of human resource management including interviewing, hiring, and counseling. Will assess plan and evaluate the unit orientation and education requirements and assure that they are met. Is responsible for the annual budget preparation including operational and capital items. Assures that hospital policies and procedures are updated and participates and coordinates unit and organizational quality improvement activities. Maintain clinical nursing skills. Appropriately intervenes in patient, family and physician issues in a timely manner. Supports and demonstrates the mission, vision and values of Kadlec Regional Medical Center.

Nursing Staff has critical care experience or attends critical care education to obtain necessary knowledge. Staff is responsible for assisting with the learning needs of new nurses, temporary help, and students in the unit. CCRN certification is recommended but not required. Life saving measures fall within the nurse's responsibility when a physician is not present. The nurse is authorized to implement standing orders, start IV's; initiate advanced life support, or adjust pacemaker settings if necessary until physician arrives.

Medical direction for ICU is provided by a Medical Director who is a Board Certified Intensivist.

Any physician on staff may admit to the unit. The Medical Director has the responsibility and authority to discuss the appropriateness of rendered care with the attending physician at any time. He/she is responsible for determining priority of admissions and discharges to the unit, including arbitration of patient priority when the unit is full.

Department Structure

The Intensive Care Unit is a 24-hour, 7-day-a-week, 40-bed unit located on the 9th and 10th floors of the River Pavilion.

Services Provided

The Intensive Care Unit is a mixed medical-surgical adult area. Typical patient types include cardiac, neuro, pulmonary and GI. Board certified Intensivists are available 24-hours a day to manage or co-manage any patients needing intensive care. Services include intra-aortic balloon pumps, dialysis, ventilator support and multiple pressor agents for hemodynamic control.

Multi-disciplinary care is provided through daily rounding and goal setting. Staff and physicians may access needed services through consulting with respiratory, pharmacy, nutrition services, cardiac rehab, wound services, chaplaincy, PT/OT/Speech or Social work services.

Patient and family education occurs throughout the patient's stay. When patients are unable to participate in education due to the severity of their illness (sedated and ventilated) family members are kept up to date on procedures and given options as to plan of care. When the patient is able they are taught about their disease and its management as well as options to treatment.

Staffing Structure

ICU: Unit Manager, Clinical Educator and Coordinator

Skill	Day FTE	Night FTE
Lead RN	1.0	1.0
RN	10-20	10-20
Unit Secretary	1-2	1-2
CNA	1-2	1-2
Tele Tech	1	1

Staffing is based on acuity. Nurse patient ratio is 1:1 or 1:2 for critical care patients. In overflow circumstances a 1:4 ratio may be permissible, (i.e., patients in the unit at hospital convenience due to high census on Med/Surgical units). An Intensive Care nurse will be assigned to role responsibilities of Trauma Resuscitation Nurse, Code Blue, Rapid Assessment Team, and Septic Shock Team at the beginning of each shift.

Key Department Relationships

ICU works closely with Respiratory, Pharmacy, Nutrition Services, and Social Work Services to assure that patient care needs are met.

KADLEC CLINIC:

Scope of Service

Mission and Purpose

Kadlec Clinic fulfills its mission by providing quality healthcare for every patient and by leading the community to better health and quality of life through the delivery of exceptional patient-centered care.

Authority and Responsibility

The Chief Operating Officer has overall responsibility for financial and operational success, and works with the Administrative Directors t to ensure best possible clinical outcomes. The practice managers have responsibility for day-to-day activities including staffing, front office business functions, back office clinical functions, evaluations, training, recruitment and retention. The Executive Team provides leadership for the day-to-day business operations. Members of the Executive Team consists of KC Chief Operating Officer, Director of Human Resources, KNC Administrative Director, IT Director, Finance Director, , Manager/Physician Recruitment, , Administrative Director/ Primary Care, Administrative Director/Specialty Care, and Administrative Director/Heart, Lung and Vascular, Chief Quality Officer, Administrative Director, Nursing Services, Administrative Director/Hematology & Oncology, Rheumatology, Practice Development Manager.

Department Structure, Hours of Operation, Staffing Structure

Kadlec Clinic has 39 clinic locations:

CLINIC	LOCATION	HOURS OF OPERATION	FTE
Audiology	1100 Goethals Dr., Suite D, Richland	8:00 AM – 5:00 PM	3.0
Behavioral Health	Variable	8:00 AM – 5:00 PM	7.0
Billing and Coding	9605 Sandifur Way, Pasco	8:00 AM – 5:00 PM	60
Cardiology	1100 Goethals Dr., Suite F, Richland	8:00 AM – 5:00 PM	45.2
Cardiothoracic (CT)	1100 Goethals Dr., Suite E, Richland	8:00 AM – 5:00 PM	6.0
Ear, Nose, Throat (ENT)	1100 Goethals, Suite D, Richland	8:00 AM – 5:00 PM	11.0
Endocrinology	1100 Goethals Dr., Suite D, Richland	8:00 AM – 5:00 PM	9.0
Fertility Center	945 Goethals, Ste. 210, Richland	8:00 AM – 5:00 PM	
Foot & Ankle	1100 Goethals Dr., Suite D, Richland	8:00 AM – 5:00 PM	9.0
Gastroenterology (GI)	900 Stevens Dr., Suite 101, Richland	8:00 AM – 5:00 PM	13.5
General Surgery (GS), Colon and Rectal Surgery	1100 Goethals Dr., Suite D, Richland	8:00 AM – 5:00 PM	13.0
Genetic Counseling	945 Goethals, Suite 220, Richland	8:00 AM – 5:00 PM	1.5
Hematology & Oncology	7360 W. Deschutes Ave, Kennewick	8:00 AM – 5:00 PM	72.44
Infectious Disease (ID)	833 Swift Blvd, Richland	8:00 AM – 5:00 PM	10.0
Interventional Radiology	1100 Goethals Dr., Suite E, Richland	8:00 AM – 5:00 PM	4.0
Kennewick Primary Care	3900 Zintel Way, Kennewick	8:00 AM – 5:00 PM	31.7
Nephrology	510 N. Colorado, Ste. A, Kennewick	8:00 AM – 5:00 PM	6.0
Nephrology	900 Stevens Dr., Richland	8:00 AM – 5:00 PM	8.0
Nephrology	3001 St. Anthony Way, Suite 115, Pendleton OR	8:00 AM – 5:00 PM	2.0
Nephrology	1050 W. Elm Ave., Ste. 160 Hermiston, OR	8:00 AM – 5:00 PM	2.0
Neurology	1100 Goethals Dr., Richland	8:00 AM – 5:00 PM	14.65
Neurosurgery	1100 Goethals Dr., Richland	8:00 AM – 5:00 PM	7.0
OB/GYN (APW)	945 Goethals Dr., Suite 200, Richland	8:00 AM – 5:00 PM	51.0
OB/GYN (Prosser)	336 Chardonnay Ave., Bldg. B, Prosser	8:00 AM – 5:00 PM	10.0
Pain Management	1100 Goethals Dr., Richland	8:00 AM – 5:00 PM	16.6

Pasco Primary Care	9605 Sandifur Way, Pasco	8:00 AM – 5:00 PM	37.0
Perinatal Center	969 Stevens Dr, Ste. 3a, Richland	8:00 AM – 5:00 PM	
Physiatry	1100 Goethals Dr., Richland	8:00 AM – 5:00 PM	5.0
Plastic Surgery & Dermatology	104Columbia Point Dr., Richland	8:00 AM – 5:00 PM	9.0
Prosser Primary Care	336 Chardonnay Ave., Bldg. A, Prosser	8:00 AM – 5:00 PM	9.8
Pulmonology	1100 Goethals Dr., Suite E, Richland	8:00 AM – 5:00 PM	6.95
Resource Pool	Variable		9 FTE; 2 Per-diem
Rheumatology	6710 W. Okanogan Pl., Kennewick	8:00 AM – 5:00 PM	25.1
Richland Primary Care	1135 Jadwin Ave, Richland	8:00 AM – 5:00 PM	29.0
Senior Clinic	560 Gage Blvd., Ste . 102, Richland	8:00 AM – 5:00 PM	34.6
South Richland Primary Care	560 Gage Blvd., Suite 101 and 206, Richland	8:00 AM – 5:00 PM	34.1
Urology	1100 Goethals Dr., Suite D, Richland	8:00 AM – 5:00 PM	10.0
Urgent Care	7233 W. Deschutes Ave., Ste. B, Kennewick	8:00 AM – 8:00 PM Monday -Sunday	31.8
Vascular Surgery	1100 Goethals Dr., Suite E, Richland	8:00 AM – 5:00 PM	6.0
West Kennewick Primary Care	9040 W. Clearwater Ave., Kennewick	8:00 AM – 5:00 PM	18.5
West Richland Primary Care	3850 Keene Road, West Richland	8:00 AM – 5:00 PM	41.0

Services Provided- Kadlec Clinic Primary Care Clinics

- Family Practice Medicine – Provided through Physicians, Nurse Practitioners and Physicians Assistants
- Pediatric services – provided through pediatricians and family practice providers
- Internal Medicine – Provided by Internal Medicine physicians and nurse practitioners as well as family practice providers
- Behavioral services and medication management provided through a psychiatric nurse practitioner.
- Minor procedures are provided on site.
- Ancillary services include X-Ray in some of the clinics.
- Point of care testing for rapid response basic lab tests are provided at the various clinics.
- Full Lab services are offered through Tri-Cities Laboratories on site at most of the clinics.

Services Provided- Kadlec Clinic Senior Care Clinic and Skilled Nursing Facilities

- Geriatric Medicine – Provided through Physicians, Nurse Practitioners and Physicians Assistants specifically trained to address the complexities involved in senior patients that have multiple chronic issues.
- Behavioral services and medication management provided through a psychiatric nurse practitioner.
- Point of Care Lab tests
- Lab services through Tri Cities Laboratory.
- Minor procedures (non emergent) performed on site.
- Provision of on-site geriatric services are also being provided on site a skilled nursing facility in Pasco.

Services Provided- Kadlec Clinic Urgent Care

- Urgent (non emergent) services provided by Physicians and Nurse Practitioners to provide assessment and diagnosis of acute issues.
- Laboratory provided on site for assessment of acute issues to include all point of care testing and diagnostic testing through a CBC machine and a Chemistry Analyzer.
- X-Ray services provided on site by Kadlec urgent care staff.
- Lab and X-ray services provided by certified x-ray and lab techs.
- Minor procedures (non-emergent) are performed on site.

Services Provided-Kadlec Clinic Speciality Clinics:

Audiology, Behavioral Health, Cardiology, Cardiothoracic Surgery, ENT, Endocrinology, Foot & Ankle, Gastroenterology, General Breast, Colon and Rectal Surgery, Genetic Counselling, Hematology & Oncology, Infectious Disease, Interventional Radiology, Nephrology, Neurology, Neurosurgery, Pain Management, Physiatry, OB/Gyn, Plastic Surgery & Dermatology, Pulmonology, Rheumatology, Urology and Vascular Surgery.

Office visits, consultations and pre op/follow up/post op appointments for various surgeries and procedures conducted in-office, at Tri City Surgery Center and/or Kadlec Regional Medical Center.

Standards

All licensed practitioners practice in a manner consistent with the State licensing authorities and WAC codes. Physicians and mid-level providers also perform duties consistent with their specialty Boards.

Key Department Relationships

Kadlec Clinic has relationships with all other departments within Kadlec Health System.

MATERNAL CHILD SERVICES:

(Birth Center, Neonatal Intensive Care Unit, Pediatrics)

Scope of Service

Mission and Purpose

Maternal-Child Services (Birth Center, Neonatal Intensive Care Unit, and Pediatrics) staff work together to provide quality, cost effective care to children, parents and families.

The **Pediatric Unit** strives to provide quality-nursing care that promotes or restores the optimal level of physical and psychological wellness of the child. Each child's unique needs and development level is considered when planning nursing care. The family or guardian of the child is strongly encouraged to be involved in direct care and care planning. Parents are welcome to stay with their child.

The **Birth Center** aims to provide quality patient care that is safe, clinically efficacious, efficient and cost effective. Emphasis is placed on supporting the childbearing family. The mother's significant other is welcome to stay. Mothers are encouraged to keep their baby with them throughout their hospital stay.

The Level III **NICU** aims to provide quality patient care that is safe, clinically efficacious, efficient, and cost effective. Nursing care provided encompasses physical, psychological, and developmental aspects of care. The unit strives to support parents and family members by being "family friendly". Parents are strongly encouraged to participate in their infant's care.

Authority and Responsibility

The Unit Manager of the Birth Center under the general direction of the Vice President of Nursing plans, directs, implements, assesses and evaluates the timely and appropriate delivery of patient care on the assigned units. Collaborates with appropriate medical staff for the overall planning of patient care across the care continuum. Participates in the development of nursing standards of patient care and standards of nursing practice consistent with current nursing research and nationally recognized professional standards; ensures standards are being met. Participates in the Medical Center planning that considers community health needs and results in development of strategic initiatives supporting the mission and vision. Develops annual capital and operational budgets, and education calendars to operationalize those initiatives.

Authority and Responsibility

The Unit Manager of the Pediatric and NICU Department follows the general direction of the Vice President of Nursing. The Unit Manager plans, directs, implements, assesses and evaluates the timely and appropriate delivery of patient care on the assigned units. Collaborates with appropriate medical staff for the overall planning of patient care across the care continuum. Participates in the development of nursing standards of patient care and standards of nursing practice consistent with current nursing research and nationally recognized professional standards; ensures standards are being met. Participates in the Medical Center planning that considers community health needs and results in development of strategic initiatives supporting the mission and vision. Develops annual capital and operational budgets, and education calendars to operationalize those initiatives.

The Unit Manager is also responsible for the day to day operation of the nursing unit. The Unit Manager ensures quality patient care by establishing and maintaining clinical standards of practice and care while meeting unit staffing requirements. The Unit Manager performs all aspects of human resource management including interviewing, hiring, and counseling. Will assess plan and evaluate the unit orientation and education requirements and assure that they are met. Is responsible for the annual budget preparation including operational and capital items. Assures that hospital policies and procedures are updated and participates and coordinates unit and organizational quality improvement activities. Appropriately intervenes in patient, family and physician issues in a timely manner. Supports and demonstrates the mission, vision and values of Kadlec Regional Medical Center.

The Medical Director for the NICU is responsible for the medical standards and direction in the NICU. The Medical Director is also responsible for the clinical supervision of the Neonatal Nurse Practitioners. This is a contracted position with the Medical Center (Seattle Children's hospital).

The Medical Director for the Pediatric Department is responsible for the medical standards and direction in the Pediatric Department. The Medical Director is also responsible for the clinical supervision of the Pediatric Nurse Practitioners. This is a contracted position with the Medical Center.

The Chief of OB/GYN provides medical direction for the Birth Center. He/she is appointed in accordance with the Medical Staff By-laws. The Chair of Pediatrics provides medical direction for the Pediatrics Unit and the wellborn nursery. He/she is appointed in accordance with the Medical Staff By-laws. The Chief of Anesthesia provides medical direction for anesthesia services in the Birth Center. He/she is appointed in accordance with the Medical Staff By-laws. Anesthesia care is the responsibility of licensed independent practitioners with appropriate clinical privileges.

Nursing care in the Birth Center, the Pediatrics Unit and NICU is provided by RNs. All OB and NICU nursing staff are required to be certified in neonatal resuscitation. Pediatric nursing staff is strongly encouraged to be certified in Neonatal Resuscitation. RNs in the Pediatrics Unit are required to be certified in Pediatric Advanced Life Support, and NICU RN's are strongly encouraged to be certified in PALS as well. Nursing staff receives assistance from Unit Secretaries. Certified Nursing assistants and OB scrub technicians. Certified Lactation Consultants are available to assist breast feeding mothers and staff. OB techs are utilized in the Birth Center to scrub c/sections, perform hearing screening exams on all newborns and other duties as assigned.

Department Structure

Description:

The **Pediatric Unit** is a 20-bed unit located on the 5th floor of the River Pavilion. There are two isolation rooms in the department. Oxygen, vacuum, emergency power outlets and nurse call system are available at each bedside. An electronic patient banding system is in place for children 10 years old and younger or for older kids as needed for added security.

The **NICU** is a 17-bed unit located on the 2nd floor of the Orchard Pavilion. There is one isolation room. Each bedside is equipped with a patient monitor for EKG, RR, invasive blood pressure and pulse oximetry. Oxygen, vacuum, compressed air, emergency power outlets, emergency call button are available at each bedside. Additional equipment may be used as needed (ventilator, bili lites, IV pumps, syringe pumps, electric breast pumps).

The **Birth Center** is adjacent to the NICU. It consists of 18 labor, delivery, recovery and postpartum (LDRP) rooms, one cesarean section suite, 4 examination/triage rooms, 4 antepartum rooms, one newborn nursery and 11 postpartum single patient rooms adjacent to the NICU. Three- LDRP rooms have the capability of negative airflow isolation. Each LDRP room is equipped with oxygen, vacuum, emergency code button and nurse call light for the mother and oxygen, vacuum, compressed air, radiant warmer, emergency code button for the newborn. The examination/triage rooms are equipped with oxygen; vacuum, emergency code button and nurse call light. The cesarean section suite is equipped for anesthesia and surgical care of the mother and neonatal resuscitation capability for multiple births. The Birth Center also has central surveillance capability for all rooms. An infant security system is in place for all newborns.

Organizational Structure:

Vice President of Nursing / Unit Manager / Coordinator/Clinical Educator

Birth Center		
Skill	Day FTE	Night FTE
Lead RN	1.0	1.0
RN	-11.0	11.0
LPN/OB Tech	1.0-2.0	1.0
Pre-Admission Clinic RN	0	
Post Partum Clinic RN	1.0	
Unit Secretary	1.0	1.0
Lactation RN	1.0	1.0

NICU

Vice President of Nursing/ Unit Manager / Clinical Educator NICU/Pediatrics			
Neonatal Nurse Practitioner 1.0 FTE			
DAYS		**NIGHTS**	
Skill	FTE	Skill	FTE
Lead RN	1.0	Lead RN	1.0
RN	5.0	RN	5.0
Unit Secretary	1.0	1.0	

Pediatrics

Vice President of Nursing/ Unit Manager / Clinical Educator NICU/Pediatrics			
DAYS		**NIGHTS**	
Skill	FTE	Skill	FTE
Lead RN	1.0	Lead RN	1.0
RN	2.0 - 3.0	RN	2.0 - 3.0
Unit Secretary 1.0			
Child Life Specialist	.50		

Services Provided

The Pediatric Center provides 24 hour nursing care to patients from newborn to 18-years of age. Medical and surgical patients are cared for. Typical patients include those with respiratory, gastrointestinal, orthopedic problems and infectious diseases and post operative patients including T& A and appendectomy. Outpatients are also cared for on the Pediatric Unit (IV therapy and chemotherapy as well). Care is also provided for neonates in stable condition without major medical problems.

The Level 3 NICU provides: 24 hour nursing care for infants with complications requiring intensive or intermediate care. Major treatment modalities include ventilator care, oxygen therapy, thermo-regulation, umbilical lines, percutaneous lines, intravenous lines, hyperalimentation, intralipids, and gavage feedings. A neonatal transport service from other facilities to KRMC is also provided. A discharge teaching class and infant CPR class are available for parents. Neonatal hearing screening is available to all infants in the NICU. A Neonatal transport service from other facilities to KRMC is also provided.

The Birth Center provides 24-hour nursing care for patients in labor, requiring cesarean section, antepartum, post partum and newborns without complications. Major treatment modalities include: antepartum testing, tocolytics for preterm labor, induction of labor, VBACS, epidural anesthesia for labor, vaginal and cesarean delivery, lactation support, patient teaching, a bereavement program for pregnancy and neonatal loss. A postpartum follow-up clinic is available to all women and babies who deliver at KRMC. Neonatal hearing screening is provided to all infants in the hospital.

Staffing

Staffing is based on acuity.

Pediatric Unit: The average nurse/patient ratio is 1:3 or 1:4.

NICU: The nurse/patient ratio is 1:1, 1:2 or 1:3.

Birth Center: The nurse/patient ratios are based on "Guidelines for Perinatal Care", 7th Edition, 2007 and Guidelines for Professional Registered Nurse Staffing for Perinatal Units, 2010.

Labor & Delivery Care

1.1	Initial Triage
1:3	Antepartum testing: NSTS, observation
1:2	Laboring patients
1:2	Oxytocin induction or augmentation of labor
1:2	Laboring patients with ongoing Epidural anesthesia (after initial placement and dosing)
1:2	Premature labor patients being stabilized on tocolytics
1:2	Initial post partum recovery

1:1	Patients in second stage, fetal distress, post partum hemorrhage
1:1	Ill patients with complications
1:1	Coverage for initiating Epidural anesthesia
1:1	Initial C-section recovery
1.1	Circulating for cesarean delivery

Mother-Baby Care:

1:2	Newborn admissions
1:4	Recently born infants and those requiring close observation
1:3/4	Mother-Baby couplets
1:6	Antepartum/post partum patients without complications
1:3	Postpartum patients with complications, but in stable condition
1:6/8	Newborns needing only routine care

Staffing is based on a matrix and nursing hours per patient day.

Standards

Care provided is based on the following standards and guidelines:

Guidelines for Perinatal Care 7th Edition, 2007

American Academy of Pediatrics

American College of OB/GYN

National Association of Neonatal Nurses

Association of Women's Health Obstetric and Neonatal Nurses

Guidelines for Professional Registered Nurse Staffing for Perinatal Units

NEURODIAGNOSTICS:

Scope of Service

Mission and Purpose

Mission:

To provide comprehensive quality care to our patients based on our values of respect, integrity, and cooperation.

Purpose:

To provide appropriate care to all the patients that require our services, based on standards of care.

AUTHORITY AND RESPONSIBILITY

Under the general direction of the VP of Professional Services, the Director plans, implements, assesses, and evaluates the timely and appropriate delivery of patient care, and collaborates with appropriate medical staff for the overall planning of patient care across the care continuum. He/she participates in the development of standards of patient care and standards of practice, consistent with current research and nationally recognized profession standards, ensuring standards are being met; participates in the Medical Center planning that considers community health needs and results in development of strategic initiatives supporting the mission and vision; develops annual capital and operational budgets and education calendars to operationalize those initiatives; and supports and demonstrates the mission, vision, and values of Kadlec Regional Medical Center.

Under the general direction of the Department Director, the Supervisor is responsible for the day-to-day operation of the unit. They ensure quality patient care by establishing and maintaining clinical standards of practice and care, while meeting unit staffing requirements. The Director and Supervisor perform all aspects of human resource management, including interviewing, hiring, and counseling; and will assess, plan, and evaluate the unit orientation and education requirements and assure that they are met. The Director is responsible for the annual budget preparation, including operational and capital items; assures that hospital policies and procedures are updated; and participates and coordinates unit and organizational quality improvement activities. The Supervisor maintains clinical skills; appropriately intervenes in patient, family, and physician issues in a timely manner; and supports and demonstrates the mission, vision, and values of Kadlec Regional Medical Center

All studies are interpreted by neurologists.

The Neurodiagnostic offices are located on the1stfloor of the main medical center and in the Healthplex.

Hours of Service

Every effort will be made to address referred patients in a timely manner based on the severity of their symptomatology, and the clinical judgment of the ordering and consulting physicians. Neurodiagnostics is staffed Monday - Friday, and on-call, evenings and weekends..

Therapeutic Services

Neurodiagnostic: EEGs, Evoked Potentials

Staffing Structure

Director		1.0 FTE
Supervisor		1.0 FTE
Neurodiagnostic Technologist		1.0 FTE + per diem

Organizational Chart:

The Neurodiagnostic staff report to the Director of Therapy Services, who in turn, reports to the VP of Professional Services.

Work Flow, Delivery System for Care & Supplies

Patients are received through general admission, outpatient admissions, and emergency admissions. Each patient is prioritized by the technologist covering a specified area. Supplies are kept in all the service areas, to allow quick and efficient delivery of ordered services.

Patient/Customer Service

Patients are encouraged to contact the technologist or other staff regarding any concerns they may have about care or services. The Director or Supervisor will follow up with the individual patient on an as needed basis. A QRR memo may be filled out by the patient/family, and it will be followed up per hospital policy and guidelines.

Standards

The Standards of Care are set forth the federal, state and local governing bodies via guidelines established for hospitals. ASET sets the guidelines for the practice of Neurodiagnostics.

Key Departmental Relationships

The Neurodiagnostic department has relationships with all other departments within the hospital structure.

(KADLEC) NEUROSCIENCE CENTER:

Scope of Service

Mission and Purpose

Kadlec Neuroscience Center fulfills its mission by offering the highest quality of care in the neurosciences using a multidisciplinary approach and evidenced-based medicine to provide optimum outcomes.

Authority and Responsibility

The Executive Director has overall responsibility for financial and operational success, and works with the President to ensure best possible clinical outcomes. The office managers have responsibility for day-to-day activities including staffing, front office business functions, back office clinical functions, evaluations, training, recruitment and retention.

Department Structure

Kadlec Neuroscience Center is located at 1100 Goethals Dr. Suite A & B. Kadlec Neuroscience Center is comprised of four specialties, Neurology, Neurosurgery, Pain management, and Physical Medicine & Rehabilitation.

Hours of Operation

Outpatient services are provided between 7:00 AM and 6:00 PM.

Services Provided

Neurosurgery: Neurosurgery services include routine outpatient visits scheduled at 1100 Goethals Dr. Suite A and emergent and urgent services at the hospital. Services in the hospital are provided on a 24/7 hour basis including emergent services in the Emergency Department and Operating Rooms. Urgent services include inpatient consultations provided in all patient care areas, including ICU. KNC neurosurgeons provide surgical services to patients with spine, cranial and peripheral nerve pathologies.

Neurology: Neurology services include routine outpatient visits scheduled in the neurology office, as well as emergent and urgent services at the hospital. Services in the hospital are provided on a 24/7 hour basis and include emergent consultations in the Emergence Department. Urgent services include inpatient consultations provided in al patient care areas, including ICU. KNC neurologists treat patients suffering from multiple sclerosis, stroke, dementia, seizures, headaches, and a number of other neuropathology disorders.

Pain Management: Pain Management providers have routine scheduled patients in clinic, and perform injection procedures at 100 Goethals Dr. Suite B and at the hospitals OPP and OR. Physicians also perform occasional non-urgent consultations in the hospital. Injection procedures are performed under fluoroscopic guidance to treat patients with pain in the spine and other major joints.

Physical Medicine and Rehabilitation (Physiatry): Physiatrists are strictly outpatient, clinic-based practitioners. Patients are routinely scheduled in clinic during office hours. Physiatrists diagnose and develop treatment plans for patients with spine and other musculoskeletal pathologies. They also perform Nerve Conduction studies.

Staffing Structure

Staffing Structure

Administrative Director1.0

Clinic Manager2.0

Front Office DMS Lead1.0

Referral Specialist8.0

Front Office Assistant 5.0

Surgical Scheduler 1.0

Registered Nurse 5.0

Medical Assistants 22.0

Radiology Tech1.0

Standards

All licensed practitioners practice in a manner consistent with the State licensing authorities and WAC codes. Physicians and mid-level providers also perform duties consistent with their specialty Boards.

Key Department Relationships

KNC has relationships with all patient-care departments in the hospital, as well as all primary care providers within Kadlec Clinic. Regular communication occurs among neurosurgeons and neurologists with hospital-based providers, nursing staff, and support personnel. KNC staff frequently communicates with surgery, nursing, and billing department staff.

NUTRITION SERVICES DEPARTMENT:

Scope of Service

Mission and Purpose

Nutrition Services staff work together to continuously improve the provision of safe, timely, high quality food service to all our customers. Clinical nutrition staff collaborates with interdisciplinary patient care staff to provide individualized nutrition care that is respectful, compassionate and appropriate for our patients.

Goals

Assure food is procured, stored, prepared, handled and served in a manner that assures safe food service for all customers.

Provide patients the food they want, , within the parameters of their diet order. The food is served in a manner that is appetizing to the customer and meets department standards for presentation and service.

Provide Café and catering services that meet the food service needs of the internal and external customers within the limitations of available resources.

Authority and Responsibility

The Nutrition Services Manager reports to the VP of Support Services, and is responsible to provide and coordinate food service in support of hospital operations; is responsible for program development and the implementation of department goals and objectives, employee development, and Performance Improvement; is responsible for the daily department operations, inclusive of menu development, coordination of the preparation and service of food and beverages for the Garden Café, Rivers Edge Deli, Lee Deli and catering customers; and maintenance of a safe and sanitary work environment. In the absence of the Nutrition Services Manager, overall department responsibility is delegated to the department Coordinator's.

The Food Service Coordinator is responsible for the allocation and utilization of staffing resources, food service staff recruitment, orientation, employee development, software system management, data analysis and reporting,

and quality control activities.

The A La Carte Coordinator is responsible for the 16-hour operation of the patient meal service system, inclusive of menu development, food preparation standards, and maintenance of a safe and sanitary work environment. Participates in staff recruitment, orientation and development, conducts quality control activities for the A La Carte area, and procures food and supplies for the department.

The Clinical Nutrition Manger reports to the VP of Support Servcies, and coordinates patient nutrition care in collaboration with multidisciplinary patient care staff to provide effective, appropriate nutritional support for all patients; and in this role, delegates nutrition care tasks as appropriate. Develops and recommends nutrition care policy and procedures, conducts clinical nutrition quality improvement activities, and assures daily access to clinical nutrition services.

Department Structure

Description:

The Nutrition Services Department is located on the first floor of the hospital with easy access to the loading dock and refuse disposal. This area was completely renovated in 1998 to facilitate efficient delivery of A La Carte patient meal service and improve overall food service operations. The main kitchen area includes space dedicated to dry and refrigerated food storage, patient and non-patient food production, ware-washing, janitor storeroom, and diet technician office. The Garden Café service area, dining room and patio are directly connected to the food service production area. The River's Edge Deli is located on the first floor of the River Pavilion. Management offices are located across the hall from the kitchen. Dietitian offices are located on main street, close to the Garden Café.

Services Provided:

Nutrition Service's primary customers include patients and their families, visitors, senior citizens, hospital staff, medical staff, Board of Directors, medical supply and service vendors, and the Child Care Center.

Patient Meal Service and Nutritional Support:

The A La Carte Patient Meal Service prepares and delivers patient meals compliant with physician diet orders 16 hours a day on demand. Clinical nutrition staff responds to interdisciplinary patient care staff referrals, and provide nutrition screening and assessment, as well as patient nutrition education. The dietitian develops nutrition care plans with input from interdisciplinary care staff which respects the individual needs of the patient, and monitors outcomes. Dietitian services are available on a daily basis.

Diet Technicians assist the patients with planning and ordering meals that are compliant with the physician order, and assures that all patients are contacted after each meal period if a meal has not been ordered.

Meal Service Representatives deliver patient meals, assist the patient with meal set-up, and respond to food service issues at the point of service; they also retrieve meal trays, and make referrals to the clinical dietitian.

Nonpatient Meal Service:

The Garden Café is open daily from 6:30 AM to 6:30 PM for use by staff and visitors. The Rivers Edge Deli, located in the River Pavilion lobby is open 6:00am to 2:00am daily. Evening shift staff may access A La Carte Patient Meal Service from 7:00 to 8:30 PM. Night shift staff may access the midnight buffet (located by the River's Edge Deli12:00 PM to 2:00 AM daily. Visitors may access A la Carte Patient Meal Service to purchase meals for delivery to the patient room 6:00AM-9:00PMdaily. Catering services are provided in support of hospital functions and business related social activities. Meals are catered to the Kadlec Child Care Center on weekdays.

Staffing Structure

Position Title	Assigned FTEs
Department Manager	1.0
Department Coordinators	2.0
Clinical Nutrition Manager	1.0
Dietitian Staff	7.5
Food Service Workers	94

Staffing flexes with volume.

Standards

Food Service is provided in a manner that is compliant with 246-215 WAC. All employees maintain current Food Service Worker Permits issued by the Benton-Franklin Public Health Department. Dietitians maintain registration through the American Dietetic Association or meet State requirements for certified nutritionist with a Masters degree. Medical nutrition therapy is based on the diet manual approved by the Medical Staff.

Key Departmental Relationships

Nutrition Services is a service department, and in that capacity ultimately interacts with and supports every department in the organization. Our primary internal customer is nursing service staff. Clinical Nutrition works closely with the Diabetes Learning Center to provide consistent diabetes education for inpatients and outpatients.

OUTPATIENT PROCEDURES:

Scope of Services

Mission and Purpose

To provide competent, compassionate quality care to our patients based on our values of respect, integrity and cooperation.

Authority and Responsibility

Under the general direction of the Director of Peri-Operative Services, the Unit Manager is responsible for the day-to-day operation of Outpatient Procedures. The Unit Manager ensures quality patient care by establishing and maintaining clinical standards of practice and care while meeting unit staffing requirements. The Unit Manager performs all aspects of human resource management including interviewing, hiring, and counseling. Will assess plan and evaluate the unit orientation and education requirements and assure that they are met. Is responsible for the annual budget preparation including operational and capital items. Assures that hospital policies and procedures are updated and participates and coordinates unit and organizational quality improvement activities. Keeps current and up to date in nursing trends and issues. Appropriately intervenes in patient, family and physician issues in a timely manner. Supports and demonstrates the mission, vision and values of Kadlec Medical Center

Department Structure

The Outpatient Procedures department includes outpatient procedures, infusion therapy and endoscopyservices.

Location: Outpatient Procedures is located on the first floor of the Orchard Pavilion. There are 9 patient cubicles and 2 procedure rooms for infusion therapy, pain management, gastrointestinal endoscopy and bronchoscopy procedures.

Hours of Operation: 0600- 1930, Monday – Friday. 2 RNs on call after hours, weekends and holidays for urgent/emergent GI/Bronchoscopy procedures.

Hours of Operation: 0700 – 1930 Monday – Friday.

Staffing Structure

Unit Manager	1 FTE
Registered Nurses	11.75 FTE
Unit Secretary	2.0 FTE
Endoscopy Technicians	3.0 FTE

Services Provided

Outpatient Procedures provides outpatient services for infusion therapy, drug pump refill, pain blocks, gastrointestinal endoscopy and bronchoscopy procedures. The outpatient procedures staff also provide assistance to the physician for inpatients who require gastrointestinal endoscopy and bronchoscopy procedures for evaluation and intervention during their hospitalization.

Key Departmental Relationships

Outpatient Procedures works collaboratively with Peri-Operative Services, Diagnostic Imaging, Clinical Decision Unit, Pharmacy, Case Management and Physicians to ensure comprehensive services for the diverse needs of our patients.

PATIENT ACCESS/ CENTRAL SCHEDULING:

Mission and Purpose

Patient Access/ Scheduling staff is responsible for all aspects of Patient Access and Central Scheduling (e.g. House wide registration, pre-authorization, exams scheduled by Central Scheduling, point of service collections) in compliance with state and federal regulations ensuring the highest level of patient, employee, physician and customer satisfaction with ethical standards. The department works to continuously improve services and ensure they are performed in a professional manner with integrity and respect.

Authority and Responsibility

The Patient Access/Scheduling Manager is responsible for the entire Patient Access department and reports directly to the Director of Revenue Cycle Operations. The Manager has the authority to plan, provide and participate in assigned projects or activities for the department, ensuring compliance with all federal and state regulations and registration documentation requirements; coordination of department work groups to ensure efficient workflow, compliance, process improvement and continuing education, and providing staff development and education to meet department standards and facilitate quality improvement.

Authority is delegated to the Patient Access/Scheduling Coordinators and Lead personnel for day to day operations, including scheduling, training, employee development and other related duties.

Services Provided

Various services are provided by responsible teams:

At Registration patient demographic data, financial information and insurance coverage are collected and entered into the Epic computer system and point of service is collected. Bedside registration is provided for the emergency department and nursing floors.

Central Scheduling schedules outpatient exams in Epic, completes pre-registration and completes estimates for out-of-pocket deductibles and coinsurance for imaging procedures.

The Authorization department obtains pre-authorization as required by third party payers and submits retro-authorizations, perform notification for bedded admits as required by third party payers, and completes surgical estimates for scheduled procedures.

A general information desk is provided in the main lobby during peak hours.

Telephone operator services are provided 24/7 and calls all hospital emergency codes overhead.

Staffing Structure

Patient Access/ Scheduling Services are distributed into four general work areas. Registration and PBX are located on the first floor of the medical center adjacent to the Emergency Department and the Laboratory. Registration also has staff on the first and second floor of the OPIC Building at 945 Goethals Dr. and first floor of the Healthplex at 1268 Lee Blvd. for our services provided in those locations. Authorization Unit Representatives are located on the 3rd floor Suite 320 of the Corrado Building, adjacent to Kadlec Regional Medical Center. Central Scheduling is located at the 2nd floor mezzanine of our Healthplex at 1268 Lee Blvd.

- Central Scheduling: Monday through Friday 7:00 am through 6:00 pm, Saturday 8:30 am through 5:00 pm (2nd fl. Mezzanine, Healthplex)
- OPIC Registration: Monday through Friday 6:15 am through 7:30 pm, Saturday 7:00 am through 5:00 pm (945 Goethals, 1st fl.)
- APW Registration: Monday through Friday 7:00 am through 5:30 pm (945 Goethals, 2nd fl.)
- Main Registration: Monday through Friday 5:45 am through 8 pm, Saturday & Sunday 7:30 am through 8:00 pm. Via Reg phone after hours
- Bedside Emergency Department Registration: 24 hours
- Bedside nursing floors (Rover): Friday-Monday 10:30 am through 9:00 pm, Tuesday-Thursday 8:30 am through 8:30 pm
- PBX: 24 hours
- Authorization Unit: Monday through Friday 6:00 am through 5:00 pm (3rd fl. STE 320 Corrado)

Patient Access/Scheduling Staffing Structure	FTEs
Director of Revenue Cycle	1.00
Manager	1.00
Lead	3.00
Coordinator	2.00
Authorization Unit Rep	6.50
Central Scheduling	19.00
Patient Access/PBX	28.50
Instructional Designer Access Services	1.00
Total	**62.00**

Standards

The Patient Access/Scheduling department complies with federal and state regulations established by the Centers of Medicare/Medicaid and Washington State Legislature. Additionally Access services maintain task specific standards for performance volumes and accuracy as defined in departmental policies and procedures.

Key Departmental Relationships

Effective interaction between Revenue Cycle and both clinical and ancillary departments is integral to fundamental department functions. Communication with clinical departments ensures both accuracy of referral/orders, timely processing, and effective communication to patients and payers regarding services provided. Ongoing relationship with Information Systems enables Access services to utilize multiple application software programs and hardware peripherals to manage workload and scheduling/registration functions.

PATIENT FINANCIAL SERVICES:

Scope of Service

Mission and Purpose

Patient Financial Service staff collects and processes information in compliance with state and federal regulations ensuring optimum reimbursement for Kadlec Regional Medical Center. The integrated PFS teams act as a resource and provide support to ancillary and clinical departments facilitating education and coordinating information with external customers. The department works to continuously improve services and ensure they are performed in a professional manner with integrity and respect

Authority and Responsibility

The Director of Revenue Cycle Operations, reporting to the Senior Director of Revenue Cycle Services is responsible for all Patient Financial Services operations ensuring compliance with all federal and state regulations and billing requirements: coordination of department work groups to ensure efficient workflow, compliance, process improvement and continuing education; maintaining cash flow to secure ongoing financial viability; and providing staff development and education to meet department standards and facilitate quality improvement. Authority is delegated to the Patient Financial Services Mangaer and Coordinatorsfor day to day operations, including scheduling, training, employee development and other related duties.

Services Provided

Patient demographic data is collected by Patient Access, then Patient Financial services uses this information move charge information through the Patient Financial Services Department to account closure. Financial Counseling obtains coverage for patients who at time of registration that do have insurance and meet coverage guidelines. Charges, generated by clinical departments, are reviewed against the patient medical record for charge accuracy and appropriate documentation by Financial Audit. Patient bills and insurance claims are generated. Claims are reviewed for accuracy and payer compliance then submitted electronically to third party payers. Accounts Receivable reviews accounts and provides necessary follow-up with payers and/or patients according to KRMC financial policy. Payments are received and posted to patient accounts. Overpayments are refunded to appropriate parties.

Staffing Structure

Patient Financial Services is distributed into three general work areas. Financial Counseling is located on the first floor of the medical center adjacent to the Emergency Department. The Director of Revenue Cycle Services, PFS Coordinators, Accounts Receivable follow-up, Billing, Financial Audit, Cash, Refunds, and department support staff are located on the fourth floor of CBC Health Sciences Building at 891 Northgate, Richland, three blocks south of Kadlec Regional Medical Center. Patient Inquiry is staffed with personnel cross-trained in areas of billing, financial counseling and collections. This staff is located in the registration area at the Healthplex to provide easy access for patients to make direct payments, financial arrangements or general inquires on accounts. This area also provides a private booth designed to accommodate confidential discussion regarding financial matters.

Patient Billing inquiry: Monday through Friday 8:30 pm – 5:00 pm (Registration area)

Patient Financial Service: Monday through Friday 5:00 am – 5:00 pm (CBC Fourth Floor)

Director	1.0
Manager	1.0
Lead/Supervisor	1.0
Coordinator	4.0
Revenue Reconciliation	10.0
SBO Self Pay/Financial Counseling	5.0
CDM/Revenue Integrity/Chart Review	1.0
Claims Specialist	1.0
Account Receivables	6.0
Billing	3.0
Total	33.0

Standards

Patient financial service standards are established according to accepted accounting principles. The department also complies with federal and state regulations established by the Centers of Medicare/Medicaid and Washington State Legislature. Additionally PFS maintains task specific standards for performance volumes and accuracy as defined in departmental policies and procedures.

Key Departmental Relationships

Effective interaction between Patient Financial Services and both clinical and ancillary departments is integral to fundamental department functions. Communication with clinical departments ensures both accuracy of charges and billing compliance. This also assists with effective communication to patients and payers regarding services provided. Close interaction with Medical Records, Coding and Patient Access improves workflow and reduces unnecessary claim delays. Case Management provides concurrent review, which effects reimbursement and support for Patient Advocacy Program. Ongoing relationship with Information Systems enables PFS to utilize multiple application software programs and hardware peripherals to manage workload and billing functions.

PERIOPERATIVE SERVICES:

(Operating Room, Pre-Surgery Unit, Post Anesthesia Care Unit, Anesthesia, Sterile Processing)

Scope of Service

Mission and Purpose

Mission:

Peri-operative Services, Operating Room, Pre-Admission Services, Pre-Surgery Unit, Post Anesthesia Care Unit, Anesthesia and Sterile Processing together provide quality cost effective care to patients in the pre-operative, intra-operative and post operative setting.

Pre-Admission Services provides pre-operative evaluation and testing for patients scheduled for surgical procedures, gastrointestinal endoscopy and diagnostic cardiology procedures.

Operating Room goals include but are not limited to meeting the physical, emotional and physiological needs of the patient and ensuring the safe delivery of care; preparation of the OR suite and the maintenance of aseptic principles.

Pre-Surgery Unit goals include but are not limited to the preparation of the patient for OR and procedures. This will include meeting the psychosocial, emotional, educational and age related needs of the patient.

Post Anesthesia Care Unit goals are the nursing support of the post-surgical patient. This includes the assessment, intervention and documentation of patient care and is age appropriate.

Sterile Processing strives is to have all instrumentation in good working condition, clean, sterile and stored in the correct location. The goal of SPD is not only to provide and render service but also to maintain quality aseptic control procedures in a continuing effort to prevent and control the spread of infection.

Authority & Responsibility

The Unit Manager, under the general direction of the Vice President of Nursing and Director of Peri-operative Services plans, directs, implements, assesses and evaluates the timely and appropriate delivery of patient care on assigned units; and collaborates with appropriate medical staff for the overall planning of patient care across the care continuum. Participates in the development of nursing standards of patient care and standards of nursing practice consistent with current nursing research and nationally recognized professional standards; ensures standards are being met. Participates in the Medical Center planning that considers community health needs and results in development of strategic initiatives supporting the mission and vision. Develops annual capital and operational budgets, and education calendars to operationalize those initiatives. Manages employees in assigned units. Supports and demonstrates the values of the Medical Center.

The Chief of Surgery provides medical direction for the Operating Room and Pre-Surgery Unit. He is appointed by the Medical Staff President per medical staff bylaws.

The Chief of Anesthesia provides medical direction for the PACU in accordance with the medical staff bylaws. The Chief of Anesthesia provides medical direction for anesthesia services. He is appointed in accordance with medical staff by-laws. Anesthesia call is the responsibility of licensed independent practitioners with appropriate clinical privileges.

Nursing care for OR, PSU, and PACU are provided both directly by qualified RNs and through support staff supervised by a RN. A qualified RN is assigned to circulating nurse duties for the OR and C-section. Documentation identifying the personnel providing direct patient care is available in the log. Documentation of assessment, nurse interventions, and care is contained in the intraoperative record on the patient's medical record.

Department Structure

Pre-Admission Services is located on the first floor of the Orchard Pavilion. There are 5 patient cubicles and 1 room for EKG testing for the pre-operative screening of patients scheduled for surgical, GI endoscopy and cardiac procedures.

Pre-Surgery Unit has eight areas designed to care for patients preparing for surgery and phase II recovery of anesthesia.

Operating Room has 8 general surgery suites designed to care for patients needing both elective and emergency surgery. Additionally, there are 2 dedicated cardio thoracic surgery suites. Perioperative Services is located in the River Pavilion in close proximity to the ICU. Operating room procedures are performed in the OR, OB, and Special Procedure areas of the hospital and governed by the Policies and Procedures of Perioperative Services.

PACU has twelve areas designed to care for patients recovering from both elective and emergency surgical procedures.

The Operating Room/PACU/SPD services are available 24 hours a day, 7 days a week. This is accomplished by a combination of regularly scheduled staff and on-call staff. The OR is open from 0600-2300, Monday-Friday and 0700-1900 on Saturday and Sunday. On call staff for OR, PACU, SPD is available for emergency cases during off-hours, holidays, and weekends. PACU is open from 0630-2200 Monday-Friday, and 0830-2100 on Saturday. SPD is open 24 hours daily Monday – Friday and 8 hours on Saturday and Sunday.

Emergency surgical procedures, requiring services of an anesthesiologist, will be covered 24 hours a day, 7 days/week throughout the year. An anesthesiologist will be available for anesthetic needs within twenty (20) minutes of notification.

Organizational Structure

Pre-Admission Services is operational 07:00-19:30 Monday through Friday. Scheduled appointments are conducted by RN's.

Perianesthesia Unit-PAU staffing is accomplished with staggered shifts Monday-Friday.

Phase I and Phase II of the PAU There are a minimum of 2 RNs available. Assignment of call to 2 RNs accomplishes 24-hour coverage. Per ASPAN standards there are always 2 RNs present.

Operating Room staffing is accomplished to meet the needs of the patient. Call is assigned to accomplish 24 hours coverage. There is a minimum of a Circulator and scrub nurse/tech assigned to all cases.

Sterile Processing - has technicians scheduled for staggered shifts. 24-hour coverage is provided by call.

Anesthesia – has scheduled one anesthesia technicians Monday – Friday to provide support and assistance to all anesthesiologists. In addition, anesthesia technicians are assigned to provide on call support.

Services

Pre-Admission Services provides pre-anesthesia assessments to screen patients for scheduled surgeries and procedures.

Operating Room - Types of surgery performed include general, trauma, orthopedic, cardiac, neurosurgery, ear, nose and throat, ophthalmology, vascular, plastic, urology, gynecology, robotics, podiatry and obstetrics. Specific procedures performed in the OR include upper and lower GI Endoscopy, arthroscopy, arteriography, and closed reduction of fractures, Swan-Ganz catheterization, Bronchoscopy, and oral surgical procedures. Types of surgery performed are consistent with the approved clinical privileges of each independent practitioner as authorized per medical staff by-laws.

Post Anesthesia Care Unit – Provides post anesthesia care for those needing recovery from anesthesia, including trauma. Discharge from the PACU is criteria based using the Aldrete Score.

Sterile Processing – Process (to include receiving, decontamination, inspect, assembly, and sterilizing), maintain and dispense instruments and equipment, and related supplies required by medical and nursing personnel clinical departments for the care, diagnosis or treatment of the patient. Participate in inservice education programs for nursing and medical personnel who utilize instruments and equipment maintained by SPD. Provide materials, which contribute to better technique of patient, care and assist in decreasing the spread of contamination. Develop processing methods and supply control methods, which will provide materials to patient care economically. Provide elements for direct patient services within designated units. Process and/or sterilize instruments and trays for use throughout the hospital monitoring all sterilization processing and biological or mechanical tests and results for sterilizers in SPD.

Anesthesia is responsible for the completion of all duties required or assigned by the Department of Anesthesia, hospital or medical staff to provide anesthesia supportive care. The Department of Anesthesia is an integral part of Medical Center and the Medical Staff. Anesthesia services are provided by a group of qualified (Board Certified or established comparable competence through the credentialing process) physicians. General, regional, local anesthesia and MAC is provided at Kadlec Regional Medical Center. Therapeutic procedures for acute and chronic pain may be performed by an anesthesiologist. When necessary, members of the Anesthesia Department may assist in the management of acute or chronic respiratory failure or insufficiency as requested by the attending physician, and management of Critical Care patient as requested by the attending physician. All anesthesiologist provide trauma care as part of a level III Trauma Center.

PHARMACY DEPARTMENT:

Scope of Service

Mission and Purpose

The Pharmacy Director is the administrative leader of the Pharmacy and is assisted in managerial, accountability, regulatory, clinical, and services by the following support staff: Assistant Director of Pharmacy, Clinical Pharmacy Coordinator, Outpatient Infusion Manager, Clinic Compliance Pharmacist, Antimicrobial Stewardship Pharmacist, and necessary support pharmacists and technician personnel sufficient to perform pharmacy related duties.

The mission of the Pharmacy Department is to provide timely, professional, and high quality medication services. We strive to optimize the patient experience by providing excellence in clinical and distributive medication services to our patients and professional staff. By ensuring safe and appropriate use of drugs within the Medical Center and by supporting Kadlec Clinic's use of medications, the pharmacy integrates best medication practices throughout the Kadlec Regional Medical Center and support services.

The following are primary focus responsibilities:

1. Monitoring appropriateness and safety of prescription and medication orders and patient drug therapy regimens. Communicating relevant findings to other practitioners directly responsible for the patient's care.
2. Controlling the preparation, distribution, and administration of drugs within the Medical Center (in compliance with regulatory mandates and current professional service standards), outpatient infusion centers, and related medication use aspects within the clinics; while preventing improper or uncontrolled use of medications throughout the regional center and clinics.
3. Providing drug information and educational counseling to patients and healthcare professionals to promote safe and appropriate use of medications.
4. Promoting appropriate, cost effective, medication use practices within the Medical Center that facilitates favorable treatment outcomes.
5. Participating in interdisciplinary quality assurance activities relating to medication use and facilitating detection, reporting, and prevention of medication errors and adverse drug reactions.
6. Executing Pharmacy and Therapeutics Committee medication policies.
7. Supporting drug related research activities within the Medical Center and infusion centers when approved by the Institutional Review Board.

Department Structure

Hours of Operation:

The Pharmacy Department is a 24 hour service operation, open continuously on all days.

Location:

The Pharmacy is located on the first floor of the Orchard Pavilion. Within the Department are work areas devoted to inpatient and outpatient prescription processing, refrigerated and non-refrigerated drug storage, sterile product compounding, automated drug distribution services, drug repackaging and compounding, information processing/data entry, drug information reference materials, and pharmacy administration.

FTE Allocation:

2005 Pharmacy Department FTEs break down as follows:

Title	# FTE
Director	1.0
Assistant Director	1.0
Clinical Coordinator	0.6
AMS Pharmacist	0.8
Pharmacy IT Specialists	4.0
Pharmacy Asst.	0.5
Pharmacy Buyer	1.0
Pharmacist	14.2
Pharmacy Technicians	23.9
340B Compliance Coordinator	1.0
Clinic Pharmacy Buyer	1.0
Infusion Clinics Pharmacy Manager	0.5
Infusion Clinic Pharmacists	3.6
Infusion Clinic Pharmacy Technicians	6.0
TOTAL FTE	**59.1**

Scope of Service

The Pharmacy Department is responsible for medication use oversight throughout the Medical Center and associated clinics. These duties are broadly outlined in the Department mission and purpose statement. Common service activities are summarized below.

1. Review, Profiling and Maintenance of inpatient medication orders.
2. Review, profiling and maintenance of infusion center medication orders.
3. Oversight of clinic medication prescribing which may or may not include review of individual drug orders.
4. Oversight of all drug related purchasing, distribution, and utilization activities within the Medical Center and associated clinics.
5. Maintenance of Providence Formulary and Kadlec specific formulary in conjunction with the Pharmacy and Therapeutics Medical Staff Committee.
6. Enforcing Pharmacy and Therapeutics Committee medication use policies.
7. Procuring and dispensing non-formulary medications for individual patients when an unusual therapy need arises.
8. Procurement and distribution of formulary drugs within the Medical Center in compliance with regulatory mandates and professional practice standards.
9. Procurement and distribution and oversight of drugs within infusion centers.
10. Procurement, distribution, and oversight of drug use and ordering in Kadlec Clinics.

11. Preparation of non-emergency sterile medication infusions
12. Oversight and maintenance of the Clinical Information system medication informatics applications.
13. Oversight of distribution, control, and security of emergency drug supplies throughout the Medical Center and associated clinics
14. Monitoring drug security and handling practices throughout the Medical Center and clinics. Inside the medical center requires a monthly inspection of every medication storage location.
15. Maintaining the Medical Center's drug recall system.
16. Handling and processing of expired medication products
17. Assuring appropriate handling and oversight of patient supplied drugs used within the Medical Center and associated clinics.
18. Investigational drug use oversight including procurement, accounting, storage, dispensing,, information dissemination, and return disposition within the Medical Center when approved by the Medical Center Research Committee.
19. Investigational drug use oversight including procurement, accounting, storage, dispensing, information dissemination, and return disposition at infusion centers when approved by research committee.
20. Monitoring of high risk, high cost, and high acuity drug therapy regimens.
21. Review of medication error/events and adverse drug reaction reports.
22. Oversight of medication safety and prevention measures relating to these events.
23. Direct medication management services provided to Medical Center patients (when authorized by the Medical Staff and approved by the Washington State Pharmacy Board).
24. Disseminating educational drug information to medical center patients, infusion center patients, and professional staff.
25. Repackaging bulk medications into unit dose bar forms suitable for bar code based documentation scanning.
26. Promoting safe medication use practices throughout the facility.
27. Ensuring compliance with controlled substance handling regulations and monitoring against medication diversion throughout the facility.

Workflow and Service Delivery

Kadlec Pharmacy is a licensed hospital pharmacy service provider under Washington State regulatory code. The Pharmacy Department utilizes a computerized patient information system which is interfaced to Pyxis' automated drug device dispensing system. These systems are used to profile, dispense, secure and bill for most medications used within the medical center and clinic. A Pyxis Narcotic Safe system is used to document and track controlled medication use throughout the facility. Within the central pharmacy, a MedCarousel system is utilized for procurement, storage, and distribution management of >80% of non-controlled drug inventory. A Pandora Data Systems/ Knowledge Portal by Carefusion application is used to track and monitor Pyxis drug security and medication use appropriateness.

Intravenous drug solutions with additives and other sterile medication products are compounded and distributed using the Epic Willow system's IV distribution module. Preparation of Adult and Pediatric / Neonatal TPN infusions is executed using the Baxa Exactamix software and compounding automation system. The Pharmacy adheres to ASHP and USP practice guidelines for sterile compounding activities. Kadlec's IV room fits into the Level 2 Risk category and conforms to USP Chapter 797 operational guidelines.

A 10 to 30 day supply of discharge medications may be provided to patients who are unable to obtain prescription drugs from other community service providers for cost or access reasons. This is not a common pathway.

Hours of Operation :

The Pharmacy provides 24-hour patient medication services to the Medical Center on all days of each year. The Pharmacy at the infusion centers is staffed 0700-1530/1700 most days as business requires.

Customer and Patient Services:

These activities are outlined above under the Mission Statement, Scope of Services, and Workflow/Delivery System Sections.

Staffing Guidelines:

Daily professional staffing is subject to adjustment depending upon workload and other contingencies. All Kadlec pharmacists and technicians are licensed under Washington State Department of Health regulatory code.

On weekdays 9-12 pharmacists provide patient care service between 24 hours a day. During weekdays, approximately 24 hours of pharmacist time is allocated to decentralized medication service activities within the adult critical care unit and adult acute care units. Night service pharmacy coverage is provided by one pharmacist and one technician. Sufficient support pharmacy technicians provide drug distribution services each weekday. The Pharmacy Director and other administrative staff provide support in the department Monday through Friday during standard business hours.

On weekends and holidays, schedule is adjusted to meet patient demand and volume expectations.

Professional and Regulatory Standards

Kadlec Regional Medical Center Pharmacy is a licensed hospital pharmacy within the state of Washington and is subject to Board of Pharmacy practice regulations. The department is also subject to Federal DEA (controlled substance) regulations, Federal legend drug regulations, Washington Department of Ecology and Federal EPA pharmaceutical waste handling regulations, HCFA (Medicare) regulations, Medicaid regulations, and HIPAA privacy regulation mandates.

The Pharmacy Department adheres to practice guidelines from the American Society of Health System Pharmacists, The Joint Commission hospital medication management standards, and current pharmacy practice literature for professional practice standard guidance.

Communication Practices

Pharmacy Staff:

Daily pharmacy huddles are attended by all available staff to discuss specific and general operational and safety needs of the department. Additionally department meetings designated for technicians are generally once each month and for pharmacists are generally once each month to every other month. All department employees are trained and expected to use the Medical Center e-mail system. The e-mail system is used extensively by the Director and other staff members to handle routine communication issues. Supplemental meetings are also scheduled to support ongoing competency maintenance activities for pharmacists and technicians. The Pharmacy Director works in the department and meets with individuals and groups of work team specialists as needed.

Performance Appraisal:

Performance appraisals are completed per Kadlec HR requirements. Success Factors is the primary mechanism to create check-in and annual review of performance. These are generally done at the end of each fiscal year. The Director evaluated and supports the following direct reports: Assistant Director, Clinical Coordinator, Infusion Pharmacy Manager, 340B Coordinator, Clinic Compliance Pharmacist. The Clinical Coordinator provides evaluation for the following direct reports: Antimicrobial Stewardship Pharmacist, Students, Pharmacy Residents, and assists the Assistant Director in evaluating their direct reports. The Assistant Director of Pharmacy provides evaluations on the following staff: Secretary, IT pharmacy staff, pharmacists, technicians. The appraisal process includes developmental goal setting for the next calendar year.

Medical Staff Communications:

The Pharmacy Director and other pharmacists communicate with medical staff members by telephone, EPIC staff messages and during daily rounds through the patient units. Professional information notes regarding drug therapy concerns are placed in EPIC as needed. Clinical iVents are also created to communicate priority therapy or safety concerns, and provide daily progress updates with adult TPN, aminoglycoside dosing, or vancomycin therapy management protocols. The pharmacy also utilizes the Navigator system to make antibiotic related recommendations and chart notes via iVents and progress notes document pharmacist clinical antimicrobial stewardship activities.

The Pharmacy Director and other Pharmacist designees attend all Pharmacy and Therapeutics Committee meetings. Pharmacy representatives also attend other medical staff committee meetings when drug therapy issues are included in the agenda. The pharmacy uses the Form Web intranet application to publish a current formulary listing, disseminate medication protocols, communicate drug safety information as well as FDA black box warnings, and also execute other pharmaceutical care communication tasks.

Key Departmental Relationships

Within the Medical Center organization tree, the pharmacy is grouped with other patient care services departments. The Pharmacy Director reports to the Vice President of Professional Affairs. A collaborative professional relationship is maintained with all nursing service departments. The pharmacy interacts with all other departments or work areas where medications are prescribed or administered. To help assure appropriate medication control and safety, Pyxis cabinets are sited in all patient care areas with significant drug dispensing activity. All medication storage areas receive monthly safety and quality assurance inspections. All policies and procedures involving medication use are reviewed and approved annually by the Pharmacy Director. He is assisted by the Assistant Pharmacy Director, Clinical Coordinator or another designee to promote accurate and timely practice and policy development. Clinical information system medication protocols are prepared under IT Pharmacist supervision and are subject to review and approval by the Pharmacy Department's Clinical Coordinator.

Performance Improvement

Key Result Measures:

Resource Management

1. Pharmacy participates on clinical pathway development-teams.
2. The Pharmacy Director collaborates with the pharmacy purchasers / buyers to monitor utilization trends and expenditures. This information is reported periodically to the Hospital Administration and the Pharmacy and

Therapeutics Committee. These groups review the data and provide input on future follow-up actions.

3. The Pharmacy Department participates in a variety of organizational performance improvement activities. Specific improvement indicator studies ongoing include 1.) Pyxis cabinet fill precision and inventory control accuracy, 2.) Pyxis override dispense frequency and appropriateness, 3.) Medication safety improvement activities. 4.) Medication error event review. 5.) Adverse Drug Reaction event clinical review and data gathering, 6) Alaris IV pump quality assurance monitoring, 7) Endotool computerized IV insulin infusion dosing for adult critical care patients, 8) EPIC system medication charting precision, and 9) Antimicrobial Stewardship patient monitoring activities.

Customer Service Activities

1. The Pharmacy's medication safety and management improvement initiatives benefit all medical center patients.
2. The Pharmacy's medication order review and drug therapy monitoring services lower medical costs and improve patient care outcomes.
3. The Pyxis cabinet unit dose drug distribution system that incorporates drug repackaging services (with bar coding) assures safe and efficient delivery of medications to Kadlec patients.
4. Pharmacists routinely provide professional advice and drug information to patients and other health care professionals to improve medication related service quality at Kadlec Regional Medical Center, Kadlec Infusion Centers, and Kadlec clinics where pharmacy services are provided.
5. Weekday clinical rounding with ICU physician intensivists.
6. Weekday clinical rounding with hospitalist physicians on inpatient Acute Care Units.
7. Pharmacokinetic Dosing Services with State approved prescriptive authority protocol.
8. Adult TPN management service with State approved prescriptive authority protocol.
9. Pharmacy drug purchasing activities utilizing Providence group purchasing contracts for inpatient medications and Federal 340b contract terms for outpatient medications to assist in containing patient care costs.
10. Clinical oversight of the Alaris Guardrail infusion pump system reduced IV infusion pump programming errors.
11. Clinical oversight of Endotool computerized insulin infusion dosing improves blood glucose control of adult critical care patients. This in-turn reduces patient morbidity and mortality.
12. Pharmacy led antimicrobial stewardship program assures pharmacist review of appropriate management of antibiotics. Interventions and review for correct drug, dose, duration and indication.
13. Pharmacy also is the primary dispensing group for diagnostic imaging related medications and face-to-face counseling and review for preparation of imaging needs.
14. The KCHO and KCR infusion clinics are staffed by competent and trained pharmacists and technicians who support both a clinical review and appropriate sterile compounding of necessary infusion therapies.

PLANT OPERATIONS:

(Facilities, Environmental Services, & Security)

Scope of Service

Mission and Purpose

Mission Statement:

We are a high performing team of professionals committed to excellent customer service while maintaining, protecting, and improving Kadlec Regional Medical Center's physical environment.

Authority & Responsibility

Director of Plant Operations:

Under the general direction of the President is responsible for the overall management of Facilities, Environmental Services, Security, Valet, Construction, and Property Management for Kadlec Regional Medical Center. The Director of Plant Operations is to establish goals and objectives, develop and implement operating policies and procedures, interpret and assure compliance with policies, regulations and codes.

Manager Environmental Services:

Under the direction of the Director of Plant Operations is responsible for managing housekeeping, laundry, and linen to ensure that Kadlec Regional Medical Center is maintained in a sanitary, attractive and orderly condition to meet The Joint Commission standards. Participates in scheduling, assigning, directing and reviewing staff. Responsible for hazardous material management for the hospital.

Plant Operations Assistant:

Under the direction of the Director of Plant Operations performs highly responsible assistance and office coordination duties for the Director of Plant Operations, and Facilities Department In addition, provides assistance to Environmental Services, Security andValet.

Facilities Manager:

Under the direction of the Director of Plant Operations, coordinates work assignments and activities of general maintenance section and overall environment of care (EOC). Schedules and directs maintenance and repair activities of buildings, grounds and utilities. Under the general direction of the Director of Plant Operations, provides for the security of patients, visitors, physicians, and employees.

Security Supervisor (contracted):

Under the direction of the Director of Plant Operations is responsible for the overall management of Security and safety services for the hospital. Addresses risks associated with the physical environment, access to security-sensitive areas and enforcement of house wide policies such as smoking and parking.

Environmental Services Supervisor:

Under the direction of the Manager of Environmental Services, schedules, assigns, and directs Environmental Services staff. Trains, supervises and inspires personnel to assure all tasks are completed and schedules met.

Valet Supervisor:

Under the general direction of the Director of Plant Operations, responsible for overall management of Valet services for the hospital. Ensures outstanding customer service and responsible for ensuring positive patient experience when accessing the facility. Trains and supervises valet attendants.

Goals

Plant Operations:

Vision:

High performing team of professionals committed to excellent customer service while maintaining, protecting, and improving Kadlec Regional Medical Center's physical environment.

Mission:

Provide a safe, functional, and secure physical environment for Kadlec employees, patients, and visitors. Continually educate on the elements of EOC and life safety to ensure continued compliance to regulatory requirements.

Structure

Hours of Operation:

Facilities - 7 days a week – 24 hours a day (holidays included)

Environmental Services – 7 days a week – 24 hours a day (holidays included)

Security – 7 days a week – 24 hours a day (holidays included)

Valet – 5 days a week – 0700 to 1800 (closed on holidays)

Locations Serviced

Facilities

• Kadlec Regional Medical Center, 888 Swift.	• Richland Medical Office Building 780 Swift Blvd, (building and departmental needsmanaged by REC),
• Child Care Center (building only, managed by REC),	• Outpatient Imaging Center (departmental needs only),
• 550 Gage (building and departmental needs, managed by REC),	• 1060 Jadwin Avenue (departmental needs only, managed by REC)
• 560 Gage (departmental needs only, managed by REC),	• 891 Northgate Health Science Center (departmental needs only, managed by REC).
• Corrado Medical Building (building and departmental needsmanaged by REC),	• 7233 Deschutes (departmental needs only,managed by REC)
• Tri-Cities Regional Surgery Center (building only, managed by REC),	• 1135 Jadwin (building and departmental needs, managed by REC
• 948 Stevens Lab (departmental needs only, managed by REC).	• 3950 Keene Rd. West Richland (building and departmental needs, managed by REC
• 1268/1270 Lee (building and department needs, managed by REC)	• 1100 Goethals, Richland, WA (building and department needs, managed by REC)
• 112 Columbia Point, Richaland, WA (building and department needs, managed by REC)	
• 3290 W. 19th Ave., Kennewick (Freestanding Emergency Department)	

Environmental Services – Locations served: Kadlec Regional Medical Center, Healthplex, KCHO and Rheumatology.

Security – Locations served: Kadlec Medical Building, Child Care Center, Parking Lots, and FSED.

Functional Areas:

Facilities – Shop, Boiler Room, Mechanical Room, Chiller Room, Penthouse, Electrical Distribution Room, Electrical Closets, Elevator Rooms, 6 Offices, Records Room, File Room, and Wood Shop.

Environmental Services – Linen Room, 2 Offices, Janitor Closets, Trash Room, Supply Room, Soiled Linen Room

Security – 1 Office

Budget:

Capital Equipment budget for Facility Services is based on repairs, replacements, or strategic initiatives for the year ranging from $500,000 to several million.

Requests for new equipment with justification areprepared by the Department Manager and submitted to the Director of Plant Operations and Capital Committee for determination.

DEPARTMENT STRUCTURE

Position	Assigned FTE
Director Plant Operations	1.0
Plant Operations Assistant	1.0
Facilities/EOC manager	1.0
Facilities Lead	1.0
Facilities Mechanic	9.0
Facilities Mechanic Assistant	1.0
Facilities Electrician	1.0
Facilities Painter	1.0
Facilities Grounds Keeper	1.0
EVS Manager	1.0
EVS Supervisor	2.0
EVS Lead	4.0
EVS House keepers	48.0
Security Supervisor	1.0 FTE contracted
Security Officer (Main Campus)	7.75 FTE contracted
Security Officer (FSED)	4.2 FTE contracted

Scope of Service:

Workflow/Delivery System:

Facility Services provides support for all departments throughout the hospital and performs PMs as

required by all regulations, codes and manufacturers recommendations.

Facilities receives work orders from departments in one of two ways (1) via Maintenance Connection which is accessed by Kweb or (2) telephone call in case of emergencies (patient care or safety). Facilities Manager or lead prioritizes and assigns work orders appropriately to members of the Facilities staff. Facilities staff members adhere to all federal, state, city, etc., regulations and codes during performance of their duties. Groundskeeper maintains Kadlec Regional Medical Center grounds.

Environmental Services works with all departments on a daily basis. Discharge Team upon patient discharge, sanitizes bed, nightstand,overbed tables, and cleans entire room. Daily cleaning of patient rooms consists of sanitizing bathroom, high dusting, dustmopping floor, damp mopping with disinfectant, and sanitizing chairs. Cleans all office and other work areas as scheduled by Supervisor. Floors are maintained daily and stripped and finished as needed. Manages linen needs throughout the hospital. Replaces paper supplies as needed. Environmental Services staff members adhere strictly to the hazardous materials and waste regulations involving cleaning supplies and trash. Staff is involved in reporting safety concerns due to the vast areas of the hospital that they come in contact with.

Security works with all departments as needed. Security officers strive to be highly visible throughout the hospital and are available for all emergencies. Security officers adhere strictly to all codes pertaining to the handling of patients, visitors, and staff, this is extremely important when it is a hostile situation.

Communications:

Plant Operations has staff meetings on a monthly basis. General departmental subjects are discussed at these meetings, i.e., construction update, safety meeting update, new product orientation and establish task force teams as needed. Discuss and exchange ideas on activities and/or projects currently taking place in the hospital, i.e. cultural diversity, Planetree philosophy, P.I.s, etc.

Performance Improvement:

Plant Operations

Participates and leads continuous improvement efforts using lean principles and PDCA process. Establishes annual goals for respective Plant Operations departments to ensure continuous improvement. Current metrics are shared during monthly staff meetings and posted on the Pursuit of Excellence board.

QUALITY CARE MANAGEMENT:

Scope of Service

Mission and Purpose

Quality Care Management (QCM) supports the clinical and non-clinical activities of the medical staff and hospital staff in their efforts to provide and improve quality patient care. The department provides patient safety coordination, , peer review, data analytic and quality consultative services for core measures and other database metrics, and facilitation and oversight of Regulatory Readiness.

Authority and Responsibility:

The Director, Quality Care Management, reports to the President of Kadlec Regional Medical Center and has been delegated the authority to direct the Department of Quality Care Management.

Patient Safety Officer reports to the Director, Quality Care Management, and is responsible to promote patient safety and direct the and reports regularly to the Board Quality Improvement Committee.

Department Structure

Quality Care Management and Patient Safety offices are located on the 2nd floor of the Mountain Pavilion.

Title	FTE
Director, Quality Care Management	1.0
Patient Safety Officer	1.0
Clinical Data Analysts	3.2
Administrative Assistants	2.0

Services Provided

QCM staff serves all patient populations.

1. **Quality and Performance Improvement:** Assist in the identification of opportunities for improvement, implementation of performance improvement initiatives and the monitoring process of opportunities identified. Collects, analyzes and reports outcomes data. Organizes, educates and supports regulatory survey preparation.
2. **Patient Safety:** Direct the Patient Safety Committee; facilitate compliance to TJC national patient safety goals; organize response to national safety initiatives; proactively identify potential patient safety issues and facilitate development and implementation of action plans to improve patient safety; monitor success of patient safety initiatives. Report activity and progress to Board Quality Improvement Committee.
3. **Data Abstraction and Analysis**: Abstracts medical records for defined data elements; submit data to national registries and fulfills regulatory reporting requirements. Analyze data and report clinical outcomes; support performance improvement initiatives.

Key Departmental Relationships

Department customers served are both external and internal which include; hospital administration, managers and staff; Medical Staff; patients and families, contracted services and vendors, insurance companies and government payers, DOH, The Joint Commission and other regulatory agencies, multiple community contracts are customers such as healthcare agencies and providers.

Quality Care Management is a service department that interacts with and supports every department in the organization. Key customers include Risk Management, VIPRO, all nursing departments, clinical staff and medical staff.

RESOURCE TEAM:

Scope of Service

Mission and Purpose

The Resource Team consists of Patient Care Coordinators, Transfer Center, Staffing Assistants, Patient Sitters, Nurse Externs, chaplain services, and a staff of RNs, CNAs, and Unit Secretaries. These services support the mission, vision and values of Kadlec Regional Medical Center by facilitating the distribution of adequate staffing and resources to provide comprehensive quality care to all patients.

Authority and Responsibility

The nurse manager reports to the Administrative Director of Nursing Services and is responsible for program development, implementation of department goals and objectives, and employee development.

Services Provided

- The Patient Care Coordinators (PCC) provide administrative coverage for hospital operations after hours in coordination with Managers, Directors, and VPs. The PCCs are primarily responsible for procuring appropriate resources to assure quality, safe patient care. The PCCs assist with appropriate staffing levels, serve as patient/family advocates, and maintain a collaborative working relationship with the staff, physicians and community. They respond to emergencies and participate in direct patient care as needed. The day time (weekend) PCC is primarily responsible for patient flow, adjustments to daily staffing, and problem solving.
- The Transfer Center nurses coordinate incoming admissions 24/7, in coordination with the PCC. The TC nurses assure adequate resources (bed and staff) are available prior to accepting the patient.
- The patient sitters provide one to one patient observation ensuring the patients are safe and do not harm themselves.
- The nurse externs perform under the direction of staff RNs in the acute care and outpatient settings within the hospital. Nurse externs perform duties as able under the Nurse Tech licensure.
- Float RNs, CNAs and Unit Secretaries work in various patient care areas of the hospital.

Resource Team Staffing Structure

A PCC is on duty 24 hours per day and seven days per week.

Patient Care Staffing Office Coverage

Seven days a week 0830-1800

Patient Care Coordinator (RNs)	4.2
Staffing Office Assistant (Clerical)	1.7
Patient Sitters	16.8

Transfer Center Services

Twenty-four hours per day/seven days per week

Transfer Center nurses	7.8

Key Department Relationships

The Resource Team has relationships with all other departments within the hospital structure.

RESPIRATORY CARE:

Scope of Service

Mission and Purpose

Mission:

To provide comprehensive quality care to our patients based on our values of respect, integrity, and cooperation.

Purpose:

To provide appropriate care to all the patients that require our services based on standards of care.

Authority and Responsibility

Under the general direction of the VP of Professional Services, the Director of Therapy Services plans, implements, assesses, and evaluates the timely and appropriate delivery of patient care, and collaborates with appropriate medical staff for the overall planning of patient care across the care continuum. He/she participates in the development of standards of patient care and standards of practice, consistent with current research and nationally recognized profession standards, ensuring standards are being met; participates in the Medical Center planning that considers community health needs and results in development of strategic initiatives supporting the mission and vision; develops annual capital and operational budgets and education calendars to operationalize those initiatives; and supports and demonstrates the mission, vision, and values of Kadlec Regional Medical Center.

Under the general direction of the Department Director, the Leadership Team, is responsible for the day-to-day operation of the unit. They ensure quality patient care by establishing and maintaining clinical standards of practice and care, while meeting unit staffing requirements. The Director and Manager perform all aspects of human resource management, including interviewing, hiring, and counseling; and will assess, plan, and evaluate the unit orientation and education requirements and assure that they are met. The Directoris responsible for the annual budget preparation, including operational and capital items; assures that hospital policies and procedures are updated; and participates and coordinates unit and organizational quality improvement activities. The Supervisor and Leadership Team maintains clinical skills; appropriately intervenes in patient, family, and physician issues in a timely manner; and supports and demonstrates the mission, vision, and values of Kadlec Regional Medical Center.

The Medical Director for Respiratory Therapy is responsible for assisting in providing direction to the department, and participates in administrative functions such as performance improvement as well.

A Medical Director may be identified for outpatient pulmonary function services.

Department Structure

Description/Location:

The physical structure of the department consists of the following; the staff and equipment rooms are located on the second floor of the main building, allowing for easy access to all areas of the hospital.

The pulmonary function testing suite is .

The RT Supervisor's office is located on the 3rdfloor of the main Building.

Services Provided

To define the scope of Respiratory Care at Kadlec Regional Medical Center the following categories will be used:

- Therapeutic Services
- Diagnostic Services

All services provide by Respiratory Care are provided by Respiratory Care Practitioners Licensed in the State of Washington.

Therapeutic Services:

Aerosol Therapy: Large and Small Volume Nebulizers; Oxyhoods with humidification; Patient and family instruction for home care

Chest Physio Therapy: Chest Physio Therapy with Postural Drainage; Intermittent Percussive Ventilation; Patient and family instruction for home care

Bronchodialator Therapy: Small Volume Nebulizers; Metered Dose Inhalers; IPV; Heliox; Heart Nebulizers

Oxygen Therapy: Oxygen analysis; Nasal Cannula; Simple Masks; Non-rebreather masks; Venti-masks; High Flow; Patient and family instruction for home care

Suctioning: Nasal Tracheal; Endotracheal; Tracheostomy; Patient and family instruction for home care

Tube Care: Tracheostomy; Endotracheal (Nasal and Oral)

Continuous Ventilatory Care: Adult Ventilator Care; Infant Ventilator Care(In-house and Transport);Nitric Oscillator; Various Modes of Ventilation including Assist Control, Pressure Support, SIMV, BiPAP, CPAP, Spontaneous, and PEEP

Non-invasive Ventilation: BiPAP

Emergency Resuscitation: Code Blue, Code Blue Pediatrics, Trauma; Septic Shock Team ; Stroke Team; Neonatal Intubation

Diagnostic Services:

Respiratory Therapy: Arterial Puncture; Analysis of arterial, venous, and capillary blood; Bedside spirometry; Complete Lung Function Testing; Capnography; Pulse Oximetry; Peak Flow assessment; Spontaneous Parameters; Pneumocardiograms (Adult and Pediatric); Patient Assessment and recommendations

EKG's: Electrocardiograms (Neonatal, Pediatric and Adult); Rhythm strips; Stroke

Staffing Structure

Director		1.0 FTE
Supervisor		1.0 FTE
Staff RT's	(26)	20 FTE + per diem

Staffing is based on patient volumes, and when needed additional staff is called in.

Organizational Chart:

The Respiratory Care staff report to the Manager who in turn reports to the Director of Rehab and Allied Health, who in turn, reports to the VP of Nursing.

Work Flow, Delivery System for Care & Supplies:

Patients are received through general admission, outpatient admissions, and emergency admissions. Each patient is prioritized by the therapist covering a specified area. Supplies are kept in all the service areas, to allow quick and efficient delivery of ordered services.

Patient/Customer Service:

Patients are encouraged to contact the individual RTs, or other staff regarding any concerns they may have about care or services. The Director or Supervisor will follow up with the individual patient on an as needed basis. A QRR memo may be filled out by the patient/family, and it will be followed up per hospital policy and guidelines.

Standards

The Standards of Care are set forth the federal, state, and local governing bodies via guidelines established for hospitals. The American Association for Respiratory Care establishes the guidelines for the practice of Respiratory Care.

Key Departmental Relationships

The Respiratory Care department has relationships with all other departments within the hospital structure.

RISK MANAGEMENT DEPARTMENT:

Scope of Service

Mission and Purpose

Risk Management supports the identification, reduction, and elimination of risk exposures that result in financial loss to the health system. Risk Management is a resource and service-oriented function designed to provide information and technical assistance on risk management issues and related problems. Risk Management works collaboratively with Quality Care Management and Patient Safety in assuring high quality patient services.

Authority and Responsibility

The Director of Risk Management reports to the Vice-President/Corporate Counsel and has been delegated the authority to direct the Risk Management Department.

The Director of Risk Management is responsible for the overall operation of Risk Management function, inclusive of program development, implementation, development of goals and objectives, performance improvement activities and staff development. Reports Risk Management issues regularly to Executive Team and Board of Directors.

The Patient Relations Registered Nurses, Patient Relations Representative, Legal Analyst, Risk Financing and Insurance Specialist, and support staff reports the Director of Risk Management.

Department Structure

Risk Management offices are located on the 2nd floor of the Mountain Pavilion.

Title	Hours of Work	FTE
Director Risk Management	Weekdays, exempt	1.0
Clinical Risk Management RN	Weekdays, exempt	1.0
Patient Relations Registered Nurse	Weekdays, exempt	1.0
Risk Reduction Specialist	Weekdays	1.0
Risk Management Analyst	Weekdays	1.0
Office Assistant	Weekdays	1.0

Services Provided: Risk serves all patient populations.

Risk Management minimizes human, financial and material loss, by coordinating a program that effectively manages actual or potential risk. Manages health system insurance program that includes a self-insured general and professional liability insurance program, claims and legal cases, patient advocacy program and quality review reporting program that includes the communication and handling of patient concerns.

Key Departmental Relationships

Department customers served are both external and internal which include: hospital administration, directors, managers and staff; medical staff; patients and families; contracted services and vendors; insurance companies and government payers; DOH; TJC; and other regulatory agencies, multiple community contracts are customers such as healthcare agencies and providers. We work with Administration and Department Directors/Managers making sure all contractual obligations of the Medical Center are compliant, legal, and up to date.

Risk Management is a service department that interacts with and supports every department in the organization. Key customers include all nursing departments, medical staff, clinical staff and patient financial services.

SUPPLY CHAIN MANAGEMENT:

Scope of Service

Mission and Purpose

One Supply Chain supports the transformation of quality, affordable care by delivering excellence through a system-wide, integrated supply chain that provides strategic leadership and services to customers and caregivers.

Goals

Achieve efficient fulfillment

Exceed the needs of our patients and caregivers

Enhance responsiveness

Facilitate Financial Success

Objective

To create, implement and maintain systems of procurement, processing and distribution so that the facility's objectives can be accomplished in the most cost efficient manner.

To enhance current systems whenever possible.

To continually strive to develop new methods of meeting the facility's goals and objectives, placing the need of those of whom we serve above all other variables.

Authority and Responsibility

The Director of Supply Chain Management reports to the Vice President of Finance. The director is responsible to administer the activities of the Supply Chain Management departments, which include purchasing, receiving, distribution, printing, mail processing, and inventory control functions. The director is responsible for the operation of the Print Shop, Mailroom, Stores and Central Supply. The director manages all operational functions and implements or updates departmental goals and objectives as needed. In the absence of the Director of Supply Chain Management, department responsibility is delegated to the VP of Finance and the Central Supply/Store Room Lead.

The Central Supply/Store Room Lead is responsible for the day-to-day operations in stores and central supply. The Director evaluates the performance of all assigned personnel; is responsible for budget development and financial performance for all Supply Chain Management departments.

Department Structure

The Supply Chain Management departments are located on the first floor of the hospital's Mountain Pavilion, with easy access to the loading dock and refuse disposal. The area was completely renovated in 1998 to facilitate efficient delivery of our supply chain services and improve overall supply chain operations.

Description

Hours of operation:

The Materials Management office is staffed for service 6:30AM to 3:30PM, Monday through Friday and is closed on all weekends and holidays. The warehouse is open 724 hours, and is open on weekends and holidays.Certain hospital staff can access the warehouse even when Supply Chain staff are not in the area.

The SCM teams are responsible for the procurement, processing, and distribution of supplies, equipment and services to the various hospital departments both main campus and offsite locations.

Purchasing buyers prepare and process all incoming stock and non-stock requisitions into purchase orders using the SCM information system.

Receiving personnel receive all materials and equipment coming into the facility, inspects shipments for accuracy and processes documentation to go to the Purchasing and Accounts Payable departments.

Stores staff replenish the storeroom shelves with incoming supplies, updates the SCMinformation system and fills departmental stock requisitions.

The SCM information system provides timely and accurate data regarding the conditions of all official inventory items and non-stock items maintained in a perpetual inventory system or non-stock requisition module. It is linked to the accounting system for the general ledger, accounts payable and budget management.

Mailroom processes and delivers all incoming and outgoing US Mail and interdepartmental mail, providing a communications system throughout the main campus and all offsite locations.

Customers include the following:

Internal customers: All KRMC departments, including offsite locations

External customers: Providence Health & Services departments and affilitaes.

Local community health service providers

Patients are served indirectly by providing medical supplies, purchase and rental of equipment and services to hospital care providers.

Patient Population:

Supply Chain Management provides supplies to all patient areas of the hospital. The department will have supplies and equipment available to provide services to patients ranging from the newborn to the geriatric population.

Scope and Complexity:

Patient care units are restocked by PAR levels. All non-stock items are procured through the traveling requisition module or special order requisition to purchasing in SCM. Capital equipment item requests are managed using the Capital Equipment Request process. All med/surg, perioperative services and other supply/equipment items are contracted through a national group purchasing organization, PH&S contract.

Supply shipments are received daily by the receiving department in SCM. The supplies are inspected, processed and either put into inventory or distributed (non-stock) to the requisitioning department.

Vendor evaluations are performed by the SCM Procurement Departmentto ascertain product satisfaction and support. The Rep Trax program located at multiplekiosks in the hospital requires all vendor sales and service representatives to register in the system upon entering the hospital. This system monitors who, where, and how long a person is in the hospital and provides documentation of information to meet health and safety requirements such as current TB test and hospital safety training. The system also provides access to individual performance grades as rated by other participating facilities.

The Value Analysis Department two reviews for analyzing the clinical need for new products and services. The reviews include members of the Regional Product Value Nalysis Team (RPVAT) and the Specialty Product Value Analysis Team (SIVAT). Both, reviews existing products for standardization, consolidation and contract compliance, and looks for process improvements, evaluations and conversions.Both teams are also expected to and documents the financial impact each product request may have to the system and requesting hospital.

Staffing Structure

Department	Assigned FTEs
Supply Chain Management	21 FTE

Staff and Qualifications:

No state certification is required. However certification by professional groups such as the Association for Healthcare Resource & Materials Management is recommended and encouraged. Valid Washington State driver's license is required and must be on file for any Supply Chain Management employee driving a KRMC owned vehicle for KRMC business.

Standards

All supply, equipment, and forms replenishment remain standard throughout the facility.

All services are rendered daily, including PAR level replenishment and equipment processing.

Supply Chain Management has the authority to commit hospital funds for acquisition of supplies and equipment to be used in the care of our patients and daily functions of our staff. Administrative approval must be obtained for certain procurement activities outlined in the hospital's policies and procedures.

THERAPY SERVICES:

Scope of Service

Mission and Purpose

Mission:

The mission of the Therapy Services Department, including physical, occupational speech, massage, therapies, as well as support staff is to be "a team of professionals who are dedicated to individualized, quality care and the restoration of function to the highest level of independence for each person".

Purpose:

To provide the highest quality of care, utilizing standards and policies to measure practice and to monitor trends and outcomes.

Authority and Responsibility

The Director of Therapy Services has responsibility for the overall operation of the department in support of hospital operations. This includes program development and the implementation of the department goals and objectives. This position reports to the VP of Professional Services.

The Manager reports to the Director and is responsible for daily operations in all settings, including conducting quality improvement and quality control activities, with responsibilities delegated to the appropriate personnel. The Manager works with a multidisciplinary staff to provide patient care in a coordinated, effective manner. In addition, the Manager participates in recruitment and training of new staff and conducts employee development reviews. Supervisors assist with daily department activities.

Department Structure

The Therapy Services Department is located in the Healthplex. Services are also provided in the acute care settings of the hospital, the inpatient rehabilitation unit on the 3rd floor of the hospital, and a physical therapy satellite clinic at Columbia Basin Racquet Club. Aquatic therapy services are available at the Healthplex.

Hours of Operation:

Outpatient services, physical, occupational, massage and speech therapy services are provided Monday through Friday from 0700-1800. Inpatient services are provided seven days a week by physical therapy, Monday through Saturday by occupational therapy and speech therapy. Speech is available as needed on Sundays. Massage therapy is available Monday through Saturday.

Customers:

- Patients / Families
- Visitors
- Medical Staff
- Hospital Staff

Services Provided

Physical Therapy – Physical Therapy Services are provided to adult and pediatric clients, in both outpatient and inpatient settings. They provide services to individuals with a variety of primary diagnosis which include, but are not limited to, the following: neurological injuries, orthopedic/sports injuries, arthritic conditions, developmental delays, musculoskeletal conditions, vestibular conditions, and wound care. Following a referral from a physician or chiropractor, the physical therapist assesses the individual and develops a plan of care and goals in conjunction with the individual. In the outpatient setting, a monthly reassessment is completed and the results are communicated with the referring physician. Weekly reassessments are completed in the acute and inpatient rehabilitation setting. For outpatients, following the course of treatment that includes home activities, a discharge summary is completed and sent to the physician.

Occupational Therapy – Occupational Therapy Services are provided to adult and pediatric clients on both an inpatient and outpatient basis. The therapists provide individualized services to people with a variety of primary diagnosis which include, but are not limited to, the following: neurological injuries, orthopedic/sports injuries, arthritic conditions, developmental delays, musculoskeletal conditions and low vision. Specialized services include off-road driving assessments, and pediatric follow-up clinics. Following a referral from a physician, the occupational therapist assesses the individual and develops a plan of care and goals in conjunction with the individual. For outpatients, a monthly reassessment is completed and the results are communicated with the referring physician. Reassessments are completed every seven days for inpatients in the acute and inpatient rehab settings. Following the course of treatment that includes home activities, a discharge summary is completed and sent to the physician.

Speech Therapy – Speech therapy services are provided on an inpatient and outpatient basis to pediatrics and adults. Services are provided to individuals with speech, language, voice, fluency, dysphagia or cognitive-communicative deficits. Individualized programs are established in conjunction with the patient, following a referral from a physician and an initial evaluation. Throughout the course of treatment, patients are provided with education and home activities. Reassessments are completed every seven days on the acute and inpatient rehabilitation services and per regulatory requirements or sooner with a status change every 30 days in the outpatient setting. Following the course of treatment a discharge summary is prepared and sent to the physician for review.

Massage Therapy – A licensed massage therapist provides services to inpatients and outpatients who are referred by their physician. Massages are provided to an adult population. The massage therapist documents visits and provides education regarding how patients are able to assist with ongoing home activities. Massage is also available to hospital employees without a physician prescription.

In addition, an independent pool group setting is offered to members of the community, included, but not limited to, former patients. This offers an individual an opportunity to continue with their water program as part of an ongoing home program.

Staffing Structure	FTE
Department Director	1.0

Manager	1.0
Supervisor	1.0
Physical Therapist	15 + per diem
Occupational Therapist	6.0 + per diem
Speech Therapist	9.0 + per diem
Office Coordinator	1.0
Schedulers	2.0 + per diem
Rehabilitation Technician	3.0 + per diem
Massage Therapist	2.5 + per diem
Occupational Therapy Assistant	1.0 + per diem
Physical Therapy Assistant	3.0 + per diem
Lift Facilitator	1.0
Recreational Therapist	per diem

Staffing needs are assessed on an ongoing basis and adjusted according to volumes and department needs.

The Therapy Services Supervisors report to their manager who reports to the Director of Rehab and Allied Health, who in turn, reports to the VP of Nursing

Standards

Licensed practitioners practice in a manner that is compliant with the WAC codes provide physical, occupational, speech, and massage services. The national guidelines are also used to provide direction for services. Speech therapists are also certified by the American Speech-Language-Hearing Association who work in accordance with the national guidelines.

Key Departmental Relationships

Therapy Services is a patient care department that interacts with all departments within the hospital. Interactions with nursing staff and physicians occur on a regular basis in the inpatient acute and inpatient rehabilitation settings. On an outpatient basis, our primary interaction is with the patient and their referral source. We also communicate with payers on a regular basis to assist with assuring a smooth flow through the rehabilitation process.

VALUE IMPROVEMENT FOR PATIENTS RESOURCE OFFICE:

Scope of Service

Mission and Purpose

Mission: The "Value Improvement for Patients" Resource Office provides leadership, consultation, and technical support using Lean and related performance improvement methodologies to collaborate with departments, teams, and cargivers across the organization to facilitate improvements in the design, management, execution, and control of operations.

Purpose: The purpose of the department is to facilitate the implementation and sustaining of a Lean culture at Kadlec Health System.

Authority and Responsibility

- The "Value Improvement for Patients" Resource Office reports to the Chief Executive, Kadlec Regional Medical Center.

Department Structure

- The "Value Improvement for Patients" Resource Office is located in Kadlec Regional Medical Center, on the second floor in the Mountain Pavilion, in the Mt. Hood conference room area.

Services Provided

- Partners with the Performance Management Council to select Lean projects, selection and development of Lean coaches, and track implementation progress. Facilitates the learning of Lean and other performance improvement methods by modeling, facilitating, and co-leading projects and initiatives. Coaches Lean project/event leaders concerning metrics management, issue resolution processes, communication plan development, and methods for sustaining work. Partners with other Providence St. Joseph Operational Excellence (OE) caregivers to spread Lean processes.

Staffing Structure

- Current staffing is 4 full-time FTEs. Staffing is comprised of the following positions:
- Director, "Value Improvement for Patients" Resource Office – 1 FTE.
- Lean Facilitator – 2 FTEs
- VIP Assistant – 1 FTE.

Standards

- Percentage of scheduling, coaching sessions completed-Goal is to complete 75% of all coaching sessions scheduled each month.
- **Key Department Relationships**
- "Value Improvement for Patients" Resource Office interacts with every department in the organization.

WOUND HEALING CENTER:

Scope of Service

Mission and Purpose

The mission of Wound Healing Center is to provide high quality, individualized wound care, to patients in an ambulatory setting using evidence-based practices. The goal is to achieve effective wound healing,

Authority and Responsibility

The Center is under the direct supervision of the Clinical Manager who reports to the Program Director and Medical Director. The Program Director reports to the Vice President of Nursing. The Vice President of Nursing reports to the KRMC President. The program director is responsible for daily operations of the department, program development, and the implementation of department goals and objectives. The clinical manager ensures that quality patient care is provided by appropriate staffing and establishes and maintains clinical standards of practice. The clinical manager performs all aspects of personnel management including interviewing, hiring, and employee coaching and counseling. The program director is responsible for budget preparation and management of cost effective practices in the department. The clinical manager assures that policies and procedures are updated and participates in department and organizational quality improvement activities. Collaboration is available directly with panel physicians as well as through the medical director.

Department Structure

The Department is physically located at Kadlec Healthplex, 1268 Lee Blvd. The hours of operation are from 8:00 a.m. to 4:30 p.m. Monday through Friday (closed holidays).

Services Provided

The Physicians and the Registered Nurses provide the following services:

History and physical examination. Complete patient assessment of systemic and local factors affecting wound healing.

Wound Cleansing and dressing changes

Wound debridement and minor surgical procedures

Compression therapy

Management of acute and chronic wounds

Off-loading and specialized orthotics to assist in initial healing of plantar ulcers and recurrence prevention.

Extensive patient instruction and education

Hyperbaric oxygen therapy

Patient Populations Served

The Wound Healing Center serves patients residing within the regional area served by Kadlec Regional Medical Center. The department provides outpatient consultation and care to patients of all ages and socioeconomic levels. Patients with acute and chronic wounds make up the specialty populations served.

Mechanism to identify patient care needs

Patient care needs are initially identified on the referral form which indicates any physical limitations, and language barriers. Arrangements for lifting help are made prior to the patient visit if appropriate. Arrangements for a certified translator are made to ensure clear communication during all visits at the Department. An education assessment is completed on the initial visit and education is continued through discharge. A teaching plan and educational literature is available for all general wound types.

Staffing Structure

Staffing is based on case load and number of active patients in clinic. The clinical manager coordinates staffing based on established guidelines. Staff positions within the center may include:

- Medical Director
- Panel physicians
- Program Director
- Clinical Manager
- Staff RN/Case Manager
- Hyperbaric Oxygen Therapy Technician
- Office Coordinator
- Staff CNA

Standards

Wound Center RNs

All nursing care is provided by registered nurses or is delegated to trained personnel as appropriate. The wound center RNs have received additional education in wound care. The majority has completed a Certified Wound and/or Ostomy and/or Continence Education Program and is nationally board certified in the areas of Wound and/or Ostomy and/or Continence. They are trained to provide care using evidence based guidelines per wound diagnosis for optimal healing. They provide education on the disease processes involved, prevention, nutritional education, wound care products and application. They assist patients with obtaining wound care products, make referrals for diabetes education, schedule appointments with local orthotists, give information on local food banks, and offer information on smoking cessation.

Key Department Relationships

The Wound Healing Center interacts with most departments of Kadlec Regional Medical Center. Referrals for outpatients come from healthcare providers in, and beyond, the Kadlec service area. The department collaborates with various disciplines, including but not limited to, physicians, laboratory personnel, Diabetes Learning Center etc, to provide a comprehensive plan of care.

Continuum of Care

A Network of Integrated Functions and Processes

Community Resources:	**Administrative Services:**	**Support Services:**	**Patient Care Services:**
Lourdes Behavioral Center	Executive Team	Transfer Center	Diagnostic Imaging
Crisis Response	Medical Executive Leadership	PCC	Chaplains Case Management
Churches	Finance	Staffing office	Social Work Services
DSHS	Foundation	Security	Hospitalist Services
Home Health	Human Resources	Supply Chain Management	Intensivist Services
Schools	Planning	Information Systems	Physicians
Red Cross	Board of Directors	Clinical Engineering	Respiratory Therapist
Subsidized Housing		Environmental Services	Pharmacy
Volunteer Center	**Education Services:**	Nutrition Services	Volunteers
Ambulance	Diabetes Learning Center	Facilities	Infection Control
Cancer Center		Child Care	Nursing Staff
Kidney Center	Neurological Resource Center	Central Registration	Inpatient Rehabilitation
Public Health	Outpatient Therapy Services	Education	Laboratory
Hospice	Healthy Ages	Health Information Management	Outpatient Specialty Services
United Way	CardioPulmonary Rehabilitation	Patient Financial Accounts	Clinical Nutrition
Senior I&A		Quality Care Management	PT/OT/Speech Therapy
Nursing Homes		Patient Registration	Cardiac Rehab
Physical Medicine & Rehab		Human Resources	Genetics Counseling
		Medical Staff	

Attachments:

Image 01
Image 02
Image%2002.png
image1.png

Approval Signatures

Approver	Date
Reza Kaleel: KRMC Chief Executive	12/2017
Heather Shipman: Executive Assistant (KRMC Chief Executive	11/2017

Exhibit 28
Utilization Review Plan

Origination:	*03/1987*
Last Approved:	*03/2017*
Last Revised:	*02/2011*
Next Review:	*02/2020*
Owner:	*Anthony Richards: Specialist, Case Management - RN*
Policy Area:	*Clinical Resource Management*
References:	

Utilization Review Plan, 1603

Document Type: Policy

SUPERSEDES: 8/08, 7/05, 1/02**,** 11/01, 3/99, 9/98, 12/95, 10/92, 8/91, 5/90, 3/87

POLICY:

Utilization Management Plan

PURPOSE:

The Utilization Management Plan is designed to assure that patient and hospital resources are appropriately allocated in the most efficient, effective, cost-effective manner ensuring quality of patient care.

AUTHORITY AND RESPONSIBILITY:

The Utilization Management Plan is developed in accordance with the hospital by-laws and with the final approval of the Board of Directors. A Utilization Review Committee is developed by a sub-committee of the Medical Executive Staff (MEC). The Medical Executive Committee (MEC) receives at least quarterly reports from the Utilization Review Committee and the utilization of resource data is presented to the Board of Directors on an annual basis.

The Utilization Management Plan is as follows:

A. The hospital will assure that data is collected to appropriately manage the utilization of resources.

B. Approved criteria and processes will be developed to assure accurate monitoring and analyzing of data collected and reported.

C. Members of the medical staff will be actively involved in evaluating the patient and hospital resources.

D. Communication mechanism will be developed to ensure that pertinent findings and recommendations from review activities are evaluated and measured to determine needs for process or performance improvement.

E. Relevant information will be integrated into performance improvement initiatives.

F. Relevant information will be shared with the medical staff and appropriate hospital personnel in other departments and services.

G. Patient utilization issues will be acted upon and resolved in a timely fashion depending on the type and urgency of the problem.

H. Prompt responses will be generated, as required, to the Medicare QIO-*Qualis*; and to other patient insurance companies as required.

I. Regularly review and measure the effectiveness of the data collected and presented by the Utilization Review Committee of the Medical Executive Committee.

UTILIZATION REVIEW COMMITTEE COMPOSITION:

The UR Committee includes a Physician Advisor who may also be a Hospitalist or Intensivist, the President of the hospital or designate, the Chief Nursing Officer or designee, the Manager of Clinical Resource Management, the Directors of H.I.M., Patient Financial Services or their designees. The Chairperson of the UR Committee assumes the responsibilities for specific department utilization issues as part of their assigned duties. The meetings are held at least quarterly and minutes are documented. Reports from the UR Committee are provided to MEC quarterly. The reports are shared with the Board of Directors annually. The data collected and reported could include:

1. Hospital Issued Notices of Non-coverage
2. Observation Days to IP Days
3. Preventable (avoidable) Days
4. Readmissions <30 days
5. Post-acute care referrals (SNF/Home health/LTAC)
6. Status report on any actions taken by committee
7. Denials/ Appeals / Case Decisions upheld or rescinded
8. Inappropriate patient-type status upon admission
9. Any continued stay patients not meeting criteria for acute care; barriers to discharge
10. Statistics related to length of stay, financial outliers and denials of service
11. Retroactive clinical reviews
12. MIM audit results
13. CMI
14. Transfer Center Stats

REVIEW PROCESS:

The Case Management Staff is responsible to identify patient utilization issues within their role as a Case Manager. The Case Management staff will make every effort to identify each area of patient care coordination where there is a potential for over or underutilization of resources. This will be accomplished through education, review of medical record, collaborating with the physician and other healthcare providers followed by documentation in the appropriate software program.

A. KRMC will cooperate with the external medical review entities, such as, Qualis Health, Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and other contracted third party payers to conduct utilization review. Outside entities must comply with established policies and procedures. The hospital will provide such entities with patient record information, as necessary to carry out their monitoring process, while assuring maintenance of confidentiality

B. KRMC will use the symptoms presented, treatment provided and parameters of discharge screening

criteria for utilization monitoring to address the question of medical necessity in terms of the "severity of illness" and the "intensity of service" (SI/IS). InterQual Criteria guidelines will be reviewed to determine the initial medical necessity status of the patient admission to the hospital.

C. Types of utilization reviews can include:
    1. Initial Review of Patient in the Emergency Department
    2. Initial Review of Patients placed into Observation status
    3. Initial Review of Inpatients
    4. Continued Stay Review of Observation/IP status
    5. Patient's Readmitted <30 days
    6. Review of Admission Criteria for Severity of Illness and Intensity of Service

D. Identification of Utilization Review problems will also include the findings of related quality assurance activities, other internal sources, and areas identified by third party payers to be reviewed

Conflict of Interest Statement:

Physicians and other health professionals may not review cases under their own care. Physicians with a personal financial interest in the hospital may not serve on the Utilization Review Committee.

CONFIDENTIALITY:

All work processed and completed is considered to be confidential and assumed to be a function of Utilization/ Quality and Risk Management. Code numbers or other identifiers will be used in place of patient, physicians, and provider names. Utilization Review documents will be given only to authorized individuals.

DISCHARGE: UTILIZATION OF POST-ACUTE RESOURCES:

A. Types of Discharge Reviews:
    1. Discharges to Skilled Nursing Facilities
    2. Discharges to Home Health Agencies
    3. Discharges to Home Infusion
    4. Discharges to Hospice

Discharge planning is the responsibility of the patient caregivers across the continuum of care. The discharge process includes the patient, families, physicians and a wide range of other involved professionals to provide the optimum discharge plan

ADOPTION OF PLAN:

The Executive Committee of the Medical Staff of Kadlec Regional Medical Center, Richland, Washington, has adopted this Utilization Management Review Plan. The Utilization Management Review Committee will review and evaluate this program every three years and recommend revisions to the Executive Committee of the Medical Staff and to the CEO of Kadlec Regional Medical Center.

Attachments:

No Attachments

Approval Signatures

Approver	Date
Anthony Richards: Specialist, Case Management - RN	03/2017