Washington State Department of Health

CN 20-24

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CERTIFICATE OF NEED PROGRAM
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WASHINGTON STATE CERTIFICATE OF NEED PROGRAM
RCW 70.38 AND WAC 246-310

APPLICATION FOR CERTIFICATE OF NEED HOME HEALTH CARE PROJECTS
(Excludes amendments)

Certificate of Need applications must be submitted with a fee in accordance with the instructions on page 2 of this form. Application is made for a Certificate of Need in accordance with provisions in Revised Code of Washington (RCW) 70.38 and Washington Administrative Code (WAC) 246-310 adopted by the Washington State Department of Health. I hereby certify that the statements made in this application are correct to the best of my knowledge and belief.

Signature and Title of Responsible Officer: Chief Strategy and Planning **Date: 12/19/19**	**Person To Whom Questions Regarding This Application Should Be Directed:** **Sarah Cameron** Chief Strategy and Planning **Telephone Number: 425-525-6656**
Legal Name of Applicant: Providence Health & Services-Oregon d/b/a Providence Home Health **Address of Applicant:** 6410 NE Halsey St Ste 300 Portland, OR, 97213 **Telephone Number: 425-525-6656**	**Type of Project (check all that apply):** [ ] New Agency [X] Existing Medicare Certified/Medicaid Eligible Agency Expanding into Different County [ ] Existing Licensed-Only Home Health Agency to Become Medicare Certified/Medicaid Eligible.
Project Summary: Providence Health & Services-Oregon d/b/a Providence Home Health intends to operate a Medicare and Medicaid certified Home Health Agency to serve residents of Clark County. **Estimated capital expenditure: $** 0	

December 20, 2019

Nancy Tyson, Executive Director
Washington State Department of Health
Certificate of Need Program
Department of Health
111 Israel Road SE
Tumwater, WA 98504

Re: Application of Providence Health & Services – Oregon d/b/a Providence Home Health to Operate a Medicare and Medicaid Certified Home Health Agency in Clark County

Dear Ms. Tyson:

Enclosed please find two copies of the certificate of need application of Providence Health & Services – Oregon d/b/a Providence Home Health to operate a Medicare and Medicaid certified Home Health Agency in Clark County.

As required, the review and processing fee of $24,666 also is enclosed.

Please contact me at 425-525-6656 or Sarah.Cameron@providence.org if you have any questions regarding this application. Thanks for your assistance.

Sincerely,

Sarah Cameron
Chief Strategy and Planning
Providence Home and Community Care

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 70.38.115 and WAC 246-310-210, 220, 230, and 240.

NOTE: **If this application is approved, the applicant will be expected to provide services to residents in the entire county.**

- Home Health applications are county specific. No more than one county per application.
- Include a table of contents for major application sections and appendices.
- Number **all** pages consecutively.
- **Do not** bind or 3-hole punch the application.
- Make the narrative information complete and to the point.
- Cite all data sources.
- Provide copies of articles, studies, etc., cited in the application.
- Place extensive supporting data in an appendix.
- Provide detailed descriptions of assumptions used for **all** projections.
- Use **non-inflated** dollars for **all** cost projections
- **Do not** include a general inflation rate for these dollar amounts.
- **Do** include current contract cost increases such as union contract staff salary increases. You must identify each contractual increase in the description of assumptions in the application.
- **Do not** include a capital expenditure contingency.

Application Submission:

Number of Copies:
- Submit an **original, one copy, and an electronic (pdf) version**
- All subsequent submissions associated with this application must be submitted with an **original, one copy and an electronic (pdf) version**.

To be accepted, the application must include:
- A completed and signed Certificate of Need application face sheet
- The review fee of **$24,666** Make check payable to ***Department of Health***

Send application to:

Mailing Address:

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

Other Than By Mail:

Department of Health
Certificate of Need Program
111 Israel Road SE Tumwater,
Washington 98504

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Introduction and Summary

Providence Health & Services - Oregon d/b/a Providence Home Health ("Providence Home Health") requests Certificate of Need ("CN") approval to operate a Medicare and Medicaid certified home health agency to serve residents in Clark County, Washington.

The Sisters of Providence, whose work formed Providence Health & Services ("Providence"), have provided services to the Vancouver, Washington, and Portland, Oregon, area since the 1850s. More than a century later, the Sisters' legacy continues to serve those in need, especially those who are poor and vulnerable. Today, Providence Home Health continues its deep tradition and heritage to provide personalized, compassionate, whole person care. Our physicians, registered nurses, therapists, and other clinical and administrative team members provide a highly-effective care team. The care and services offered by Providence Home Health includes but is not limited to skilled nursing, physical therapy, occupational health, speech therapy, social services, and home health aide services.

Providence Home Health operates out of its branch offices in Portland, Seaside, and Hood River, currently providing services in the following Oregon counties: Clackamas, Clatsop, Columbia, Hood River, Marion, Multnomah, Polk, Tillamook, Wasco, Washington, and Yamhill. The proposed agency will be based out of the Providence Home Health office in Portland. On average, Providence Home Health provides more than 240,000 home health visits annually representing approximately 11,000 unique patients annually. Providence Home Health employs more than 400 clinical and administrative staff.

The agency will serve all patients requiring home health services in Clark County, with an emphasis on underserved populations, especially the poor and vulnerable. Providence Home Health intends to provide a full range of home health services to all appropriate patients, regardless of insurance status or ability to pay.

Providence Home Health remains a leader in the industry and actively participates in state and national organizations. Quality, safety, and clinical excellence have been core tenets of the organization since its inception. Committed to achieving compliance with all local, state, and federal regulations, Providence Home Health has never had any license revocations.

Ultimately, Providence Home Health is pursuing a certificate of need to establish a home health agency in Clark County, Washington for two reasons:

1. Serve the unmet and growing needs of the population in Clark County
2. Support enhanced continuity of care for patients interacting with the Providence care delivery system

Need Is Shown For A New Home Health Agency in Clark County

In order to determine whether there is need for new home health agencies, the Department of Health ("Department") relies upon the home health numeric need model

published in the 1987 Washington State Health Plan ("SHP").[1] Utilizing the forecasting method, the numeric need for additional home health agencies is calculated for each county using a three-year "planning horizon."

According to the Department's October 2019 Home Health Numeric Need Methodology, there is a gross need in Clark County for 14 home health agencies in the target year of 2022. When examining the existing home health agencies, the Department lists 15 agencies with seven (7) CN approved agencies that are Medicare and Medicaid certified. With the existing supply of seven CN approved home health agencies and a gross need of 14 agencies by 2022, this indicates a net need of seven (7) Medicare and Medicaid certified agencies by 2022 in Clark County.

Providence Home Health intends to meet that need by operating a Medicare and Medicaid certified home health agency to serve residents in Clark County. The home health agency will be based out of the existing Portland office that currently services adjacent counties in Oregon.

An Integrated Care Delivery Network with Broad Support

As part of an integrated care delivery system, Providence Home Health works closely with existing Providence providers and partners in the Portland Metropolitan service area, including those in Clark County. Providence has a significant presence with the Providence Portland hospitals, where patients from across the region come for care. Providence works with specialists who see patients from Clark County – patients who may be best served by home health care at some point in their home.

Providence has established strong relationships in the Clark County community, both in the health delivery sector, as well as with community support organizations. Providence is a well-established provider of primary care in Clark County, as the Providence Medical Group has a total of four primary care clinics in Clark County, with the first clinic opening in 2009. Providence also was recently awarded a Certificate of Need in December 2019 to establish a hospice agency in Clark County, further allowing us to care for patients across the continuum of care. We are proud to support many organizations in the community that have a mission in caring for the poor and the vulnerable, which is in alignment with the Providence mission. Some of these organizations include: Share House, YMCA, Free Clinic of Southwest Washington, Children's Center, CDM Caregiving Services, Evergreen Habitat for Humanity, and the Council for the Homeless.

Furthermore, year-to-date in 2019, Providence Health Plan has approximately 4,252 Medicare Advantage health plan members in Clark County. From this perspective, we are seeking to support the best continuity of care possible to serve the broader community, including but not limited to serving the needs of patients in the Providence Health Plan.

In addition, Providence Home Health is supported by existing home health colleagues within Washington State who are based in Olympia, Tukwila, Spokane, and Everett. With

[1] The Washington State Health Plan has been sunset but remains the reference utilized by the Department for calculating the home health need model.

this depth of expertise, we are well positioned to identify and share best practices, improve quality outcomes, promote financial stewardship, increase access, and improve patient satisfaction across the care continuum.

Providence Is Committed To, and Has Deep Roots in, the Local Community
As a long-established provider, Providence Home Health has deep roots in and is fully committed to the local community in northwest Oregon and southwest Washington. Providence Home Health currently works closely with community partners, local hospitals, physicians, and other providers to ensure comprehensive post-acute care that improves access and continuity of care. Providence Home Health serves all patients requiring home health services, with an emphasis on underserved populations, especially the poor and vulnerable.

Finally, the Providence Mission reaches beyond the walls of care settings to touch lives in the places where relief, comfort, and care are needed. The Providence Mission reads: *As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.* One way Providence lives the Mission is through providing community benefit. These investments not only support the health and well-being of our patients, but the whole community. Through programs and donations, Providence'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. Providence provides significant community benefit in the form of free and discounted care; community health grants, and donations; education and research programs; unfunded government-sponsored medical care; and subsidized services. In 2018, Providence provided $617 million in community benefit in Washington and $278 million in community benefit in Oregon.[2]

When the Sisters of Providence began their tradition of caring nearly 160 years ago, they greatly depended on partnering with others in the community who were committed to the same aims. Today, we collaborate with social service and government agencies, charitable foundations, community organizations, universities, local providers, and many other partners to identify the greatest needs and create solutions together.

[2] Please see Table 11 below for details about Providence Health & Services Washington and Oregon community benefit, 2018.

I. APPLICANT DESCRIPTION

A. Provide the legal name(s) of applicant(s).

The legal name of the applicant is Providence Health & Services-Oregon d/b/a Providence Home Health.

B. For each licensed applicant, please provide the professional license number and specialty represented. If the license was not issued by Washington State, please identify the state it was issued.

- Providence Home Health is currently licensed as a Washington in Home Services Agency, with license # IHS.FS.60108399.
- Providence Home Health is currently licensed as a Medicare certified agency through Oregon State accreditation, with license number 38-7048.
- Providence Home Health's Oregon Medicaid license number is 241348.
- Providence Home Health is accredited with The Joint Commission, with accreditation number 320680.

C. <u>For existing facilities</u>, provide the name and address of the facility.

While Providence does not have an existing office presence in Clark County, it will administer services to Clark County out of its Portland-based offices. The names and addresses are provided below:

<u>Licensed Address</u>: 6410 NE Halsey St, Ste. 300, Portland, OR, 97213

- Providence Home Health is licensed out of the above address, but most clinical staff for home health services are based in nearby offices. The facility at 6410 NE Halsey St. houses Home Health Administration, Hospice Administration, Specialty Pharmacy, Infusion Services, and Home Medical Equipment, among other services. Providence owns the facility located at this address.

<u>Office Location (Portland)</u>: 4400 NE Halsey St, Building 1, Ste. 160, Portland, OR 97213

- This office location currently serves home health patients in Oregon counties. Upon CN approval, it will provide home health services in Clark County.

D. Identify the type of ownership (public, private, corporation, non-profit, etc.).

Providence Health & Services–Oregon d/b/a Providence Home Health is a private, non-profit organization – 501(c)(3).

E. Provide the name and address of *owning* entity at completion of project (unless same as applicant).

This question is not applicable. The owning entity is the same as the applicant.

F. Provide the name and address of *operating* entity at completion of project (unless same as applicant).

This question is not applicable. The owning entity is the same as the applicant.

G. Identify the corporate structure and related parties. Attach a chart showing organizational relationship to related parties.

Providence has facilities located in Alaska, Washington, Montana, Oregon, California, New Mexico, and Texas. For the purposes of this CN application, the Providence Health & Services legal structure has been provided in Exhibit 3. In addition, an organizational chart for Providence Health & Services–Oregon d/b/a Providence Home Health is provided in Exhibit 4.

On July 1, 2016, Providence Health & Services and St. Joseph Health System, a California non-profit corporation, became affiliated. The new affiliation creates a new "super-parent," Providence St. Joseph Health, a Washington non-profit corporation. It is important to note that Providence Health & Services remains a viable corporation as do any and all subsidiaries and d/b/as that fall under that corporate umbrella. This new affiliation does not change the name or corporate structure of Providence Health & Services or Providence Home Health. Finally, a copy of Oregon Health Authority business license information for Providence Health & Services–Oregon d/b/a Providence Home Health is provided in Exhibit 5.

H. Provide a general description and address of each facility and other related business(es) owned and/or operated by applicant (include out-of-state facilities, if any).

A list of all Providence facilities that are related to post-acute care (including home health, hospice, home infusion pharmacy, durable medical equipment, PACE[3], skilled nursing facilities, and other residential care settings) is provided in Exhibit 6.

[3] "PACE" is the Program for All-inclusive Care for the Elderly.

I. <u>For existing facilities</u>, identify the geographic primary service area.

Providence Home Health provides services in the following counties in Oregon: Clackamas, Clatsop, Columbia, Hood River, Marion, Multnomah, Polk, Tillamook, Wasco, Washington, and Yamhill. Figure 1 contains a map of the current counties served by Providence Home Health

The current service area for Providence Home Health naturally lends itself to providing the needed services in Clark County, with Providence Home Health bringing experience and capabilities to serve both populous and more remote communities.

In addition to a strong commitment in Oregon, Providence is a major provider of home health services in Washington. Providence currently serves Thurston, Mason, Lewis, Pierce, King, Snohomish, Spokane, Stevens, Walla Walla, and Columbia Counties, along with Camano Island in Washington.

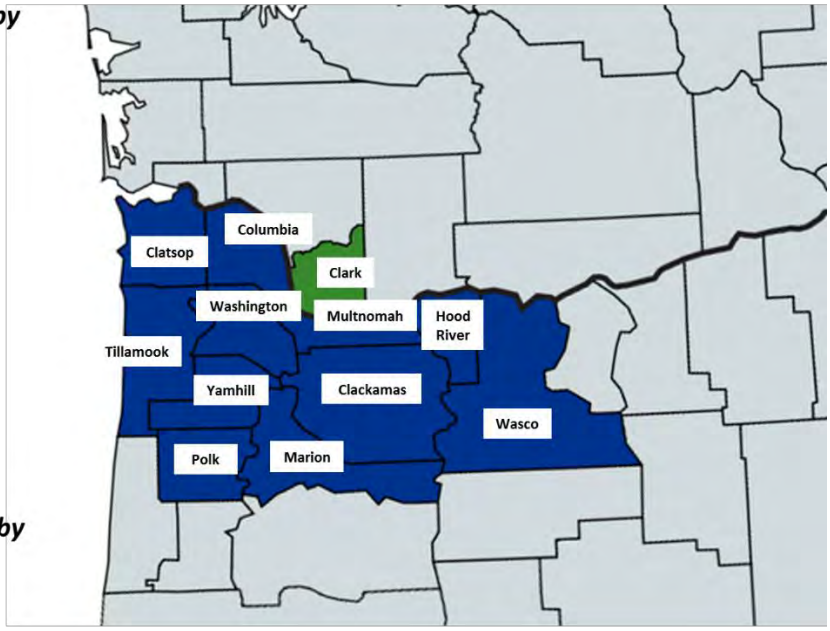
Figure 1. Providence Home Health Current and Proposed Counties Served in OR and WA

<u>Current</u> Counties served by Providence Home Health

- Clackamas, OR
- Clatsop, OR
- Columbia, OR
- Hood River, OR
- Marion, OR
- Multnomah, OR
- Polk, OR
- Tillamook, OR
- Wasco, OR
- Washington, OR
- Yamhill, OR

<u>Proposed</u> County Served by Providence Home Health

- Clark, WA



Source: Providence

J. Identify the facility licensure/accreditation status.

- Providence Home Health is currently licensed as a Washington In Home Services Agency, with license # IHS.FS.60108399.

- Providence Home Health is currently licensed as a Medicare certified agency through Oregon State accreditation, with license number 38-7048.
- Providence Home Health's Oregon Medicaid license number is 241348.
- Providence Home Health is accredited with The Joint Commission, with accreditation number 320680.

K. Is the applicant reimbursed for services under Medicare and Medicaid? List which ones.

Providence Home Health is reimbursed under Titles XVIII and XIX of the Social Security Act.

L. If applicable, identify the medical director and provide his/her professional license number, and specialty represented.

Providence Home Health employs Ruth Medak, M.D. as the Medical Director. Per the Oregon Medical Board, Dr. Medak (#MD09230) has an active Physician and Surgeon License with no enforcement actions. Dr. Medak is board certified in Internal Medicine and is board certified in Hospice and Palliative Care. Please see Exhibit 7 for a copy of Dr. Medak's Oregon provider credential details.

M. If applicable, please identify whether the medical director is employed directly by or has contracted with the applicant. If services are contracted, please provide a copy of the contract.

Providence Home Health employs Ruth Medak, M.D. as the Medical Director through Providence Health & Services – Oregon. Please see Exhibit 8 for a copy of the Providence Home Health Medical Director job description. Once this CN application is approved, the job description will be amended to include the oversight duties relating to Clark County. Since Dr. Medak is an employee of Providence, no contract is required.

N. <u>For existing facilities</u>, please provide the following information broken down by discipline (i.e., RN/LPN, OT, PT, home health aide, social worker, etc.) <u>for each county</u> currently serving:

1. **Total number of home health *visits* per year for the last three years; and**
2. **Total number of unduplicated home health *patients* served per year for the last three years.**

The data provided in Table 1 provides a holistic view of Providence Home Health that includes the provision of services in the following Oregon counties: Clackamas, Clatsop, Columbia, Hood River, Marion, Multnomah,

Polk, Tillamook, Wasco, Washington, and Yamhill. In addition see Exhibit 13 for the patient origin analysis and Exhibit 14[4] that provides home health patients served by service type and county.

Table 1. Providence Home Health Visits and Unduplicated Home Health Patients 2016-2019

	Historicals			Annualized
Providence Home Health (without project)	**2016**	**2017**	**2018**	**2019**
Home Health Visits	231,289	235,945	240,420	245,046
Unduplicated Home Health Patients	11,153	13,048	10,845	12,132

Source: Providence

[4] Please note that the data provided in Exhibit 14 does not illustrate unduplicated or unique patients. It represents the number of patients served for each service type, and a single unique patient may have been provided with more than one service type during the period.

II. PROJECT DESCRIPTION

A. Provide the name and address of the proposed facility.

While Providence does not have an existing office presence in Clark County, it will administer services to Clark County out of its Portland offices. The name and addresses are provided below:

Licensed Address: 6410 NE Halsey St, Ste. 300, Portland, OR, 97213

- Providence Home Health is licensed out of the above address, but most clinical staff for home health services are based in nearby offices. The facility at 6410 NE Halsey St. houses Home Health Administration, Hospice Administration, Specialty Pharmacy, Infusion Services, and Home Medical Equipment, among other services. Providence owns the facility located at this address.

Office Location (Portland): 4400 NE Halsey St, Building 1, Ste. 160, Portland, OR 97213

- This office location currently serves home health patients in Oregon counties. Upon CN approval, it will provide home health services in Clark County.

B. Describe the project for which Certificate of Need approval is sought.

Providence Health & Services-Oregon d/b/a Providence Home Health seeks to operate a Medicare and Medicaid certified home health agency to serve residents of Clark County. The home health agency will be based out of Providence Home Health's offices located in Portland, Oregon. Providence Home Health will not have office locations in Clark County but will serve Clark County from adjacent counties in Oregon.

C. List new services or changes in services represented by this project. In the following table, please indicate (by marking an 'X' in the appropriate column) which services would be provided directly by the agency and which services would be contracted.

Please see Table 2 below.

Table 2. Home Health Services Provided

	Direct	Contracted
Skilled Nursing	X	
Physical Therapy	X	
Occupational Health	X	
Speech Therapy	X	
Medical Social Work	X	
Home Health Aide	X	
IV Therapy	X	

Source: Providence

D. General description of types of patients to be served by the project.

The proposed agency will serve all patients requiring home health services in Clark County, with an emphasis on underserved populations, especially the poor and vulnerable. Providence Home Health intends to provide a full range of home health services to all appropriate patients, regardless of insurance status or ability to pay.

E. List the equipment proposed for the project:

1. **Description of equipment proposed; and**
2. **Description of equipment to be replaced, including cost of the equipment, disposal, or use of the equipment to be replaced.**

The proposed agency will required only minor equipment that is included as part of the start-up costs. The equipment includes one PC and peripherals (screen, keyboard, mouse, etc.) and one printer. Please see Exhibit 18 for details and costs. Outside of some minor supplies listed in Exhibit 18, there are no other proposed equipment costs.

F. Provide drawings of proposed project:

1. **Single line drawings, approximately to scale, of current locations which identify current department and services; and**
2. **Single line drawings, approximately to scale, of proposed locations which identify proposed services and departments; and**
3. **Total net and gross square feet of project.**

The agency will be based out of Providence Home Health's existing offices, located in Portland, Oregon. The existing administrative infrastructure is well positioned to support census growth into Clark County. This will initially allow Providence Home Health to increase services in Clark County without adding additional staff in the first several months of operation.

Please see Exhibit 9, which contains single line drawings for the office space where home health staff will be located. The office space is located at the following address:

- 4400 NE Halsey Street, Building 1, Portland, OR 97213
    - For the entire building, there is 185,099 GSF and 179,943 NSF square feet, respectively.
    - For Suite 160 (the space that the project will jointly occupy with Providence Health & Services dba Providence Hospice), there is 8,065 GSF and 7,831 NSF.

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

Obtaining a certificate of need to operate a home health agency in Clark County is an essential element of our long-range strategic plan to meet the needs of the residents of Clark County. Through this application, Providence is seeking to ensure strong continuity of care as people seek specialty care across the state border. Home health is an essential part of the overall care continuum and is fully supported in our long-range planning expectations.

Providence Home Health will provide home health services in Clark County in addition to the seven existing Medicare and Medicaid certified home health agencies in Clark County, as the demand for home health services will continue to increase. The proposed expansion of home health agency services is in response to current utilization trends and in preparation for the future need for more home health services in Clark County, as established by the Department's Home Health Numeric Need Methodology. This will better serve the residents' increasing health care needs.

Finally, Providence is committed to enhancing whole person care[5] by engaging people where they live, work, and play. Providence continues to integrate exceptional medical care with consistent attention to the personal experiences and well-being of the patients and families we serve.

I. Provide documentation that the applicant has sufficient interest in the site or facility proposed. "Sufficient interest" shall mean any of the following:

1. **Clear legal title to the proposed site; or**
2. **A lease for at least one year with options to renew for not less than a total of three years; or**

[5] Whole person care is generally defined as health care based on medical, emotional, and personal needs. Whole person care means that: patients are full partners in decisions about all aspects of their care; families receive help supporting loved ones who are seriously ill; and professional caregivers receive help coping with the strains of caregiving.

3. **A legally enforceable agreement (i.e., draft detailed sales or lease agreement, executed sales or lease agreement with contingencies clause) to give such title or such lease in the event that a Certificate of Need is issued for the proposed project. These agreements may be in draft form if all parties identified in the draft agreements provide a signed "Letter of Intent to finalize" the agreement.**

Please see Exhibit 10, which demonstrates Providence has sufficient interest in the Portland facilities that serve as the clinical and administrative office space for Providence Home Health.

Exhibit 10 includes titles for the following:

- 4400 NE Halsey Street, Building 1, Portland, OR 97213, which is the location where home health clinical staff will be located to serve Clark County. Providence owns the facility located at this address.
- 6410 NE Halsey St, Ste. 300, Portland, OR, 97213, which houses Home Health Administration, Hospice Administration, Specialty Pharmacy, Infusion Services, and Home Medical Equipment, among other services. Providence owns the facility located at this address.

III. PROJECT RATIONALE

A. NEED (WAC 246-310-210)

1. Identify the proposed geographic service area.

Providence Home Health seeks to operate a Medicare and Medicaid certified home health agency to serve residents of Clark County, Washington.

2. If the proposed service area is designated as a Medically Underserved Area (MUA) as defined by HCFA or a Health Professional Shortage Area (HPSA), please provide documentation verifying the designation.

According to the Washington State Department of Health, portions of Southwest Clark County are considered a Medically Underserved Area (MUA). Please see Exhibit 11 that highlights the portion of Clark County considered an MUA. In addition, according to Health Resources & Services Administration, please see Exhibit 11 that details facility HPSA designations in Clark County.

3. Identify and analyze the unmet home health service needs and/or other problems toward which this project is directed.

a. Identify the unmet home health needs of the patient population in the proposed service area. Note that the unmet patient need should not include physical plant deficiencies and/or increase facility operating efficiencies.

In assessing the need for home health services in Clark County we used (1) the methodology provided in the 1987 Washington State Health Plan [6] and (2) the most recent DOH needs assessment for home health agencies in Clark County (dated October, 2019).

Providence Home Health intends to operate a home health agency in Clark County. To assess need in Clark County, we provide the following step-by-step analysis as provided by the Washington State Department of Health October 2019 home health methodology.

There are four steps in assessing need in Clark County, which are provided below:

Step 1: Identify projected population in Clark County broken down by age cohorts (0-64; 65-79; 80+).

[6] The Washington State Health Plan has been sunset but remains the reference utilized by the Department for calculating the home health need model.

The Clark County population projections are provided in Table 3. These projections are based on the 'OFM 2017 GMA Projections – Medium Series', as used by the Department of Health Certificate of Need Program ("the Department") in its October 2019 home health need methodology.

Table 3. Clark County Population Projections

Clark County			
Age Cohort	**2020**	**2021**	**2022**
0-64	417,273	421,901	426,529
65-79	64,681	67,002	69,323
80+	17,444	18,684	19,924
Total	499,398	507,587	515,776

Source: DOH Home Health Methodology (October 2019).

Step 2: Apply the estimates for home health use rates for each age cohort to derive projected patient visits for Clark County.

The projected patients in Clark County are provided in Table 4. The projected patients by age cohort are based on the 1987 Washington State Health Plan, as reflected in the DOH October 2019 home health need methodology.

Table 4. Clark County Projected Patients by Age Cohort

Clark County				
Age Cohort	**Use Rate**	**2020**	**2021**	**2022**
0-64	0.005	2,086	2,110	2,133
65-79	0.044	2,846	2,948	3,050
80+	0.183	3,192	3,419	3,646
Total		8,125	8,477	8,829

Source: DOH Home Health Methodology (October 2019);
Use Rates from Washington State Health Plan

Step 3: Apply the estimates for projected patients for each age cohort to derive projected patient visits for Clark County.

The projected number of visits for each age cohort in Clark County are provided in Table 5. The projected visits by age cohort are based on the 1987 Washington State Health Plan, as reflected in the DOH October 2019 home health need methodology.

Table 5. Projected Visits by Age Cohort

Clark County				
Age Cohort	**# of Visits**	**2020**	**2021**	**2022**
0-64	10	20,864	21,095	21,326
65-79	14	39,843	41,273	42,703
80+	21	67,037	71,803	76,568
Total		127,744	134,171	140,597

Source: DOH Home Health Methodology (October 2019)

Step 4: Estimate home health agency need.

The projected number of home health agencies for Clark County are provided in Table 6.

The projected visits by agencies are based on dividing patient visits by 10,000 (the minimum required volume for a home health agency) as noted in 1987 Washington State Health Plan and as reflected in the DOH October 2019 home health need methodology.

Table 6. Projected Home Health Agencies

Clark County			
	2020	**2021**	**2022**
Patient Visits	127,744	134,171	140,597
Visits per Agency	10,000	10,000	10,000
# of Agencies	12.77	13.42	14.06

Source: DOH Home Health Methodology (October 2019)

As noted in Table 6, the projected home health agencies needed by 2022 for Clark County is 14.06.

In order to determine net need for home health agencies, we examined the existing supply of home health agencies. To determine existing supply, we relied on the definition supplied in WAC 246-310-010 (30) that states the following: *"Home health agency" means an entity which is, or has declared its intent to become, certified as a provider of home health services in the Medicaid or Medicare program.* Using the definition above as a guide when assessing existing supply of home health agencies, we included only Certificate of Need approved agencies that provide services to the Medicaid and Medicare patients.

Table 7. Existing CN Approved (Medicare/Medicaid) Home Health Agencies

Agency	License Number	CON Approved	Counties Served
Community Home Health and Hospice	IHS.FS.00000262	Yes	Clark
Kindred at Home	IHS.FS.00000300	Yes	Clark
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Yes	Clark, Skamania
Aveanna Healthcare (Pediatric Services of America)	IHS.FS.00000422	Yes	Clark
Touchmark Home Health	IHS.FS.00000454	Yes	Clark
PeaceHealth Hospice and PeaceHealth Homecare	IHS.FS.60331226	Yes	Clark
Healthy Living at Home - Vancouver LLC	IHS.FS.60814521	Yes	Clark

Source: DOH Home Health Methodology (October 2019).

Based on the list of agencies provided by the DOH in the '2019.10' home health need methodology for Clark County, there are 15 agencies in Clark. Of the 15 agencies in Clark County, a total of seven (7) are CN approved. Please see Table 7.

When examining the existing supply of CN approved home health agencies versus the calculated need, there is a net need of seven agencies in Clark County. Please see Table 8.

Table 8. Net Need for Home Health Agencies

Home Health Agencies Net Need (Clark)	
Existing Home Health Agencies *	15
Existing Medicare/Medicaid Certified Home Health Agencies*	7
Projected Need for Home Health Agencies in 2022 *	14.06
Net Need for Home Health Agencies in 2022	**7.06**

Source: *DOH Home Health Need Methodology (October 2019).

To support Tables 3, 4, 5, 6, 7 and 8, please see Exhibit 12 for the full DOH home health need methodology.

b. Identify the negative impact and consequences of unmet home health needs and deficiencies.

Home health services include skilled nursing, physical therapy, occupational therapy, and activities of daily living, such as, bathing dressing, skin care, and mobility. Home health is critical in providing the right care in the right place.

As outlined above, the DOH home health need methodology shows Clark County will have an unmet need for seven home health agencies by 2022. The existing supply of seven CN-approved home health agencies is not sufficient to meet the demonstrated need in the county. If a new home

health agency is not approved, access to home health services will be limited. This may result in Clark County residents either seeking care in more costly hospital-based settings or not seeking the appropriate care at all. The proposed expansion of services into Clark County will allow Providence to continue to provide for the health care needs of the growing community.

4. **Define the types of patients that are expected to be served by the project. The types of patients expected to be served can be defined according to specific needs and circumstances of patients (i.e., culturally diverse, limited English speaking, etc.) or by the number of persons who prefer to receive the services of a particular recognized school or theory of medical care.**

Providence Home Health offers exceptional skilled care for patients of all ages, with all medical diagnoses, within the comfort of their home. Patients may have a new diagnosis or illness; be coping with a chronic condition, such as heart failure or diabetes; or recovering from surgery, such as a total hip or knee replacement or recent hospitalization.

Home health services are provided for patients who need:

- Care and teaching related to a newly diagnosed illness, such as diabetes, heart or lung disease, or cancer
- Care for a worsening illness or condition
- Follow-up care or rehabilitation from surgery, stroke, illness or injury
- Education about new treatments or medications (including pharmacy consulting), and monitoring of their progress
- Education for themselves and their family/caregivers how to provide care or how to operate and maintain in-home medical equipment
- Health care and emotional support during a terminal illness
- Wound care

Providence Home Health has a number of specialty teams for Palliative Care, Mental Health, and Wound Ostomy nurses to meet the diverse needs of the community. Providence Home Health also has a close working relationship with the home and community-based continuum of care, including hospice, pharmacy, respiratory therapy, and home medical equipment.

In addition, Providence Home Health has an established remote patient monitoring program for heart failure that would extend the same services to Clark County patients. In this program, we have dedicated nurses who deliver the monitoring devices to the patient's homes, provide education

about the device, and monitor the daily alerts as patients upload their information. Currently, we have approximately 50 devices in the Portland area and are looking to expand the program to other diagnosis in the near future. Our main goal with the program is to reduce unnecessary hospitalizations in this patient population.

Finally, it should be emphasized that Providence provides care for all patients needing home health services. Home health patients are treated and cared for regardless of gender, ethnicity, disabilities, or their ability to pay.

5. **For existing facilities, include a patient origin analysis for at least the most recent three-month period, if such data is maintained, or provide patient origin data from the last statewide 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.**

Please see Exhibit 13 for the patient origin analysis for Providence Home Health. The three-month period is Q1 2019.

6. **For existing facilities, please identify the number of patients currently receiving skilled services, broken down by type(s) of services (i.e., skilled nursing), by county served.**

Please see Exhibit 14 for a breakdown of the number of patients served by service type and county. The data is annualized for 2019.

Please note that the data provided in Exhibit 14 does not illustrate unduplicated or unique patients. It represents the number of patients served for each service type, as a single unique patient may have been provided with more than one service during the period.

7. **Please provide utilization forecasts for the following, broken down by discipline (i.e., RN/LPN, OT, PT, social worker, etc.) for each county proposing to serve:**

   a. **Total number of home health visits per year for the first three years; and**
   b. **Total number of unduplicated home health patients served per year for the first three years.**

Please see Table 9 for a utilization forecast by discipline for the proposed agency serving Clark County.

Table 9. Forecast by Discipline for Clark County

Discipline	July 2020 - Dec 2020	2021	2022	2023
RN/LPN	1,332	3,330	3,996	4,440
Physical Therapy	981	2,453	2,943	3,270
Home Health Aide	162	405	486	540
Speech Therapy	93	233	279	310
Occupational Therapy	354	885	1,062	1,180
Medical Social Work	78	195	234	260
Total Patient Visits	**3,000**	**7,500**	**9,000**	**10,000**
Total Unduplicated Patients	150	375	450	500

Source: Providence

8. Provide the complete step-by-step quantitative methodology used to construct each utilization forecast. <u>All assumptions related to use rate, market share, intensity of service, and others must be provided.</u>

The following assumptions and methodologies were used to construct the utilization forecast for Providence Home Health in Clark County:

The Project (Clark County Home Health Forecast):

- The project is assumed to start as of July 1, 2020 or upon CN approval.
- Given the level of projected unmet need by 2022 in Clark County (140,597 visits), total project utilization is assumed to reach capacity of one agency (10,000) by 2023 with moderate ramp-up assumed in prior years.
- Total need was based on the standard use rate assumed by the Washington State Health Plan:
  - Age Cohort 0-64 – use rate of 0.005
  - Age Cohort 65-79 – use rate of 0.044
  - Age Cohort 80+ – use rate of 0.183
- Utilization forecasts by discipline are then estimated using the following distribution of visits based on the current YTD 2019 levels for the existing operations of Providence Home Health:
  - Skilled Nursing – 44.4%

- Physical Therapy – 32.7%
- Occupational Therapy – 11.8%
- Home Health Aides—5.4%
- Speech Therapy—3.1%
- Social Workers—2.6%

Existing Operations (without "The Project"):

- Current operations based on Providence Home Health – Portland.
- 2019 Forecast "base" visit volume of 242,640.
- 2020 visit volume based on 6% year-over-year growth rate in-line with current budgeted expectations for total existing volume.
- 2021-2023 visit volume based on 2% annual growth rate.
- Inflation is excluded from the forecast (both with and without the project)

9. Provide detailed 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 (licensed only and certified) similar to those proposed and provide utilization experience of those providers that demonstrates that existing services are not available to meet all or some portion of the forecasted utilization.

As noted in Exhibit 12, there are 15 existing home health agencies in Clark County. Of the 15 existing agencies, seven agencies are Medicare/Medicaid certified home health agencies. According to the DOH home health need methodology, there is projected need for 14.06 home health agencies by 2022. With seven existing Medicare/Medicaid home health agencies, this suggests a net need of 7.06 home health agencies in Clark County. With a net need of seven additional home health agencies, the current providers are not sufficient to meet the needs in the community.

b. If existing services are available, demonstrate that such services are not accessible. Unusual time and distance factors, among other things, are to be analyzed in this section.

Of the seven Medicare/Medicaid certified home health agencies in Clark County, only four have provided Medicare Fee for Service visits since 2015. According to their Web site, Aveanna Healthcare (Pediatric Services of America) provides pediatric care only. Kaiser Permanente provides services only to its members. According to data available from Berg Data Solutions, Healthy Living at Home has had no discernible presence in Clark County since 2015.

Timely access to home health services provides a key measure of overall access. Based on 2018 data, timely access to home health services in Clark County was far below state and national averages. The four Medicare/Medicaid certified agencies that provided Medicare FFS visits in 2018 reported timeliness outcomes below state and national averages for speed of admission from hospital discharge to home health agency. This suggests that Clark County would benefit from the proposed Providence Home Health agency. Please see Table 10 below.

Table 10. Clark County Timeliness of Care

	2018 Speed of Admission from Hospital Discharge to Home Health Agency (Medicare FFS)		
	0 - 1 Days	0 - 2 Days	0 - 3 Days
National Average	***56%***	***78%***	***87%***
WA State Average	***27%***	***53%***	***70%***
Kindred at Home	24%	42%	59%
PeaceHealth Homecare	19%	38%	60%
Community Home Health and Hospice	13%	37%	56%
Touchmark Home Health	13%	24%	51%

Source: Berg Data Solutions

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

As noted in Exhibit 12 and the discussion above in Section I.A.3, there is net need for seven home health agencies in Clark County. Given that there is unmet need in the community, the proposed agency is, by definition, not an unnecessary duplication of services.

10. Document the manner in which low-income persons, racial and ethnic minorities, women, people with disabilities, and other under-served groups will have access to the services proposed. The department uses the applicant's current or proposed status as a Medicare and Medicaid certified provider of service as part of its evaluation of question.

As a long-established provider, Providence has deep roots in the Clark County community and a strong reputation for serving the needs of all. In alignment with our Mission and commitment to our community, the proposed home health agency will serve all patients requiring home health services in Clark County, with an emphasis on underserved populations, especially the poor and vulnerable. Providence Home Health intends to provide a full range of home health services to all appropriate patients, regardless of insurance status or ability to pay.

In addition, the Providence Mission reaches beyond the walls of care settings to touch lives in the places where relief, comfort, and care are needed. One important way Providence does this is through providing community benefit. These investments not only support the health and well-being of our patients, but the whole community. Through programs and donations, Providence'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. Providence provides significant community benefit in the form of free and discounted care; community health, grants, and donations; education and research programs; unfunded government-sponsored medical care; and subsidized services. In 2018, Providence provided $617 million in community benefit in Washington and $278 million in community benefit in Oregon. Please see Table 11 for more information.

Table 11. OR and WA Community Benefit, 2018

Oregon Community Benefit, 2018	
Service	**Amount**
Unfunded portion of Government-sponsored medical care	$162.3 Million
Free and Discounted Medical Care	$53.9 Million
Community health, grants and donations	$17.8 Million
Education and research programs	$38.2 Million
Subsidized services	$5.8 Million
Total (Oregon Community Benefit)	**$278.0 Million**
Washington Community Benefit, 2018	
Service	**Amount**
Unfunded portion of Government-sponsored medical care	$415.0 Million
Free and Discounted Medical Care	$81.6 Million
Community health, grants and donations	$23.3 Million
Education and research programs	$74.0 Million
Subsidized services	$23.4 Million
Total (Washington Community Benefit)	**$617.3 Million**

Source: Providence

11. Please provide copies (draft is acceptable) of the following documents:

a. Admissions policy; and
b. Charity care policy; and
c. Patient referral policy, if not addressed in admissions policy.

- Please see Exhibit 15 for the Admission Criteria Policy. The Admission Criteria Policy addresses patient referrals.
- Please see Exhibit 16 for the Admission Process Policy
- Please see Exhibit 17 for the Financial Assistance Patient Services Policy.

Following CN approval, Providence Home Health will update the policies to reference the provision of home health services in Washington, not only Oregon.

12. As applicable, substantiate the following special needs and circumstances that the proposed project is to serve.

a. The special needs and circumstances of entities such as medical and other health professions' schools, multi- disciplinary clinics, and specialty centers that provide a substantial portion of their services, resources, or both, to individuals not residing in the health services areas in which the entities are located or in adjacent health services areas.

This question is not applicable.

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.

This question is not applicable.

c. The special needs and circumstances of osteopathic hospitals and non-allopathic services with which the proposed facility/service would be affiliated.

This question is not applicable.

B. Financial Feasibility (WAC 246-310-220)

WAC 246-310-990(2) defines "total capital expenditure" to mean the total project costs to be capitalized according to generally accepted accounting principles. These costs include, but are not limited to, the following: legal fees; feasibility studies; site development; soil survey and investigation; consulting fees; interest expenses during construction; temporary relocation; architect and engineering fees; construction, renovation, or alteration; total costs of leases of capital assets; labor; materials; fixed or movable equipment; sales taxes; equipment delivery; and equipment installation.

1. **If applicable, provide the proposed capital expenditures for the project. These expenditures should be broken out in detail and account for at least the following:**
   - **Land acquisition;**
   - **Site survey, tests, and inspections**
   - **Construction contract;**
   - **A financial feasibility study, architectural fees/engineering fees/consulting fees;**
   - **Fixed equipment (not in construction contract);**
   - **Movable equipment;**
   - **Freight and delivery charges;**
   - **Sales tax;**
   - **Cost of tuning up and trial runs;**
   - **Reconditioning costs (in case of used asset);**
   - **Cost of title investigations, legal fees, brokerage commissions;**
   - **Other activities essential to the acquisition, improvement, expansion, or replacement of plant and equipment due to the project; and**
   - **Financing cost statement, including interim interest expense, reserve account, interest expense, and other financing costs.**

This question is not applicable, as there are no capital costs for this project.

2. **Explain in detail the methods and sources used for calculating estimated capital expenditures.**

This question is not applicable, as there are no capital costs for this project.

3. **Document the project impact on: (a) Capital costs (b) Operating costs and charges for health services.**

Please see Exhibit 18, which includes the pro forma forecast showing operating revenue and expenses for the first three full years of operations. There is no impact on capital costs, as no capital is required for this project.

4. **Provide the total estimated operating revenue and expenses for the first three years of operation (please show each year separately) for the items listed below, as applicable. Include all formulas and calculations used to arrive at totals on a separate page.**

Please see Exhibit 18, which includes a pro forma forecast showing all operating revenue and expenses for the first three full years of operations. Included in Exhibit 18 are the assumptions and start-up costs used in the forecast. Where appropriate, the assumptions include relevant unit of service or percentage increases for expenses and revenues. The start-up costs are for the project only (Clark County agency) and are incorporated in the July – December, 2020 expense totals.

5. **Please note: according to revised HCFA regulations, home health agencies must have enough reserve funds (determined by an authorized fiscal intermediary) to operate for three months after becoming Medicare/Medicaid certified. Please provide the following information in relation to this requirement:**

    1. **Provide the name and address of the fiscal intermediary you will be using to determine capitalization; and**

    The Regional Home Health Intermediary address is noted below:

    National Government Service, Inc.
    Provider Enrollment
    P.O. Box 6474
    Indianapolis, IN 46207-7149

    2. **Provide a copy of the forms you are providing to the fiscal intermediary.**

    The Regional Home Health Intermediary requires entities complete the Provider/Supplier Enrollment Application Form (CMS-855A). As of writing this application this form has not been completed, as Providence Home Health has not received Certificate of Need to establish a home health agency in Clark County. If required by the Department, Providence Home Health will submit a copy of the form after the CN is approved.

6. **Identify the source(s) of financing (loan, grant, gifts, etc.) for the proposed project. Provide all financing costs, including reserve account, interest expense, and other financing costs. If acquisition of the asset is to be by lease, copies of any lease agreements, and/or maintenance repair contracts should be provided. The proposed lease should be capitalized with interest expense and principal separated. For debt amortization, provide a repayment schedule showing interest and principal amount for each year over which the debt will be amortized.**

This question is not applicable, as there is no financing for this project.

7. **Provide documentation that the funding is, or will be, available and the level of commitment for this project.**

This question is not applicable, as there is no financing for this project.

8. **Provide a cost comparison analysis of the following alternative financing methods: purchase, lease, board- designated reserves, and interfund loan or bank loan. Provide the rationale for choosing the financing method selected.**

This question is not applicable, as there is no financing for this project.

9. **Provide a pro forma (projected) balance sheet and expense and revenue statements for the first three years of operation.**

Please see Exhibit 19, which includes a balance sheet pro forma for the first three full years of operation.

10. **Provide a capital expenditure budget through the project completion and for three years following completion of the project.**

This question is not applicable, as there are no capital expenditures for this project.

11. **Identify the expected sources of revenue for the applicant's total operations (e.g., Medicare, Medicare Managed Care, Medicaid, Healthy Options, Blue Cross, Labor and Industries, etc.) for the first three years of operation, with anticipated percentage of revenue from each source. Estimate the percentage of change per year for each payer source.**

Please see Table 12 below, which provides both the 2018 and the forecast payer source mix for the project. The payer mix is modeled to remain the same for the first three full years of operation. The projected payer mix is based on the most recent full year of data for Providence Home Health.

Table 12. Providence Home Health Forecast Payer Mix

Payer Mix	2018	Forecast (2020-2023)
Medicare FFS	31.7%	31.7%
Medicare Managed Care	50.8%	50.8%
Medicaid	0.8%	0.8%
Medicaid Managed Care	7.4%	7.4%
Commercial	8.5%	8.5%
Self-Pay	0.2%	0.2%
Other (L&I, TRICARE, VA)	0.6%	0.6%
Total	100.0%	100.0%

Source: Providence

12. If applicant is an existing provider of health care services, provide expense and revenue statements for the last three full years.

Please see Exhibit 20 for the expense and revenue statement for Providence Home Health.

In addition, please see Exhibit 22 for 2016-2018 audited financials for Providence St. Joseph Health.

13. If applicant is an existing provider of health care services, provide cash flow statements for the last three full years.

Please note that Providence does not hold cash flow statements at the facility level, and Providence does not routinely use facility level cash flow statements as part of its financial analysis when evaluating new business ventures. With that said, for purposes of this Application and to satisfy the Department's questions relating to cash flow statements, Providence has prepared a cash flow statement. This cash flow statement was solely created for the Department's review of this Application. Please see Exhibit 21 for a cash flow statement for last three full years.

In addition, please see Exhibit 22 for 2016-2018 audited financials for Providence St. Joseph Health that includes cash flow statements.

14. If applicant is an existing provider of health care services, provide balance sheets detailing the assets, liabilities, and net worth of facility for the last three full fiscal years.

Please note that Providence does not hold a balance sheet at the facility level, and Providence does not routinely use facility level balance sheets as part of its financial analysis when evaluating new business ventures. With that said, for purposes of this Application and to satisfy the Department's questions relating to a balance sheet, Providence has prepared a balance sheet. This balance sheet was solely created for the

Department's review of this Application. Please see Exhibit 21 for a balance sheet for the last three full years.

In addition, please see Exhibit 22 for 2016-2018 audited financials for Providence St. Joseph Health that includes balance sheets.

15. For existing providers, provide actual costs and charges per visit broken down by discipline (i.e., RN/LPN, OT, PT, social worker, etc.) and by payer source.

Please see Table 13, which provides actual costs and charges by discipline.

Table 13. Providence Home Health Actual Costs and Charges per Visit[7]

Home Health Agency - Actuals (2019)		
Discipline	**Costs per Visit**	**Charges per Visit**
RN/LPN	$ 238	$ 285
Physical Therapy	$ 222	$ 266
Home Health Aide	$ 117	$ 140
Speech Therapy	$ 309	$ 369
Occupational Therapy	$ 237	$ 283
Medical Social Work	$ 276	$ 329
Payer Source	**Costs**	**Charges**
Medicare Fee for Service	$ 67.98	$ 80.63
Medicare Managed Care	$ 119.04	$ 141.18
Medicaid	$ 1.69	$ 2.00
Medicaid Managed Care	$ 20.25	$ 24.02
Commercial	$ 21.25	$ 25.21
Self Pay	$ 0.19	$ 0.23
TOTAL	**$ 230.41**	**$ 273.27**

Source: Providence

16. Provide anticipated costs and charges per visit broken down by discipline (i.e., RN/LPN, OT, PT, social worker, etc.) and by payer source.

Please see Table 14, which provides anticipated costs and charges broken down by discipline and by payer source. The anticipated costs are assumed to be the same as the actual costs.

[7] Note: Due to rounding, multiplying costs or charges by visit volume will produce slightly different total dollar amounts than what is provided in Exhibit 20.

Table 14. Providence Home Health Anticipated Costs by Payer Type[8]

Home Health Agency - Forecast		
Discipline	**Costs per Visit**	**Charges per Visit**
RN/LPN	$ 238	$ 285
Physical Therapy	$ 222	$ 266
Home Health Aide	$ 117	$ 140
Speech Therapy	$ 309	$ 369
Occupational Therapy	$ 237	$ 283
Medical Social Work	$ 276	$ 329
Payer Source	**Costs**	**Charges**
Medicare Fee for Service	$ 67.98	$ 80.63
Medicare Managed Care	$ 119.04	$ 141.18
Medicaid	$ 1.69	$ 2.00
Medicaid Managed Care	$ 20.25	$ 24.02
Commercial	$ 21.25	$ 25.21
Self Pay	$ 0.19	$ 0.23
TOTAL	**$ 230.41**	**$ 273.27**

Source: Providence

17. Indicate the addition or reduction of FTEs with the salaries, wages, and employee benefits for each FTE affected, for the first three years of operation. Please list each discipline separately.

Please see Table 15 that provides a breakdown of the FTEs for the project, which includes existing FTE, incremental FTE, and total FTE by discipline.

[8] Note: Due to rounding, multiplying costs or charges by visit volume will produce slightly different total dollar amounts than what is provided in Exhibit 18.

Table 15. Providence Home Health FTE Forecast[9]

INTERNAL STAFFING	July-Dec 2020	2021	2022	2023
Cumulative Existing FTE (As Is - Without Project)				
RN/LPN	159.2	162.4	165.7	169.0
Physical Therapy	90.7	92.6	94.4	96.3
Home Health Aide	15.4	15.7	16.1	16.4
Speech Therapy	10.8	11.0	11.2	11.5
Occupational Therapy	35.3	36.0	36.7	37.4
Medical Social Work	9.5	9.6	9.8	10.0
Administrative / Clerical	64.7	66.0	67.3	68.7
Management / Supervisor	27.9	28.4	29.0	29.6
Other	2.5	2.6	2.6	2.7
Subtotal Existing FTE	**416.0**	**424.3**	**432.8**	**441.6**
Cumulative New FTE (The Project)				
RN/LPN	1.4	3.6	4.3	4.8
Physical Therapy	1.1	2.6	3.2	3.5
Home Health Aide	0.2	0.4	0.5	0.6
Speech Therapy	0.1	0.3	0.3	0.3
Occupational Therapy	0.4	1.0	1.1	1.3
Medical Social Work	0.1	0.2	0.3	0.3
Administrative / Clerical	0.5	1.0	1.3	1.5
Management / Supervisor	0.0	0.3	0.8	1.0
Other	0.0	0.0	0.0	0.0
Subtotal Incremental FTE	**3.7**	**9.3**	**11.7**	**13.3**
Cumulative New and Existing FTE (As Is + The Project)				
RN/LPN	160.6	166.0	170.0	173.8
Physical Therapy	91.8	95.2	97.6	99.8
Home Health Aide	15.6	16.1	16.6	17.0
Speech Therapy	10.9	11.3	11.5	11.8
Occupational Therapy	35.7	37.0	37.8	38.7
Medical Social Work	9.6	9.8	10.1	10.3
Administrative / Clerical	65.2	67.0	68.6	70.2
Management / Supervisor	27.9	28.7	29.8	30.6
Other	2.5	2.6	2.6	2.7
TOTAL FTE	**419.7**	**433.6**	**444.5**	**454.9**

Source: Providence

In addition, please see Table 16 that includes current Providence Home Health salaries and benefits for 2018.

[9] Medical Director is included in Administrative / Clerical

Table 16: Providence Home Health Salaries and Benefits (2018)[10]

INTERNAL STAFFING	Salary	Benefits
RN/LPN	$ 106,680	$ 29,337
Physical Therapy	$ 94,004	$ 25,851
Home Health Aide	$ 41,216	$ 11,334
Speech Therapy	$ 96,001	$ 26,400
Occupational Therapy	$ 95,828	$ 26,353
Medical Social Work	$ 82,614	$ 22,719
Administrative / Clerical	$ 48,878	$ 13,441
Management / Supervisor	$ 113,154	$ 31,117
Other	$ 48,138	$ 13,238

Source: Providence

18. Please describe how the project will cover the costs of operation until Medicare reimbursement is received. Provide documentation of sufficient reserves.

Providence Home Health is an existing facility with annual patient home visits of more than 240,000 visits in 2018. While Providence Home Health does not carry reserves, it has sufficient cash from operations from its existing business to ensure the costs of operations are covered until Medicare reimbursement is received for proposed home health agency covering Clark County.

In addition, please see Exhibit 22 for 2016-2018 audited financials for Providence St. Joseph Health.

[10] Medical Director is included in Administrative / Clerical

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

1. Please provide the current and projected number of employees for the proposed project, using the following:

Please see Table 17 that provides the projected FTE by type. Please see Table 15 for the current FTE by type.

Table 17. Projected FTE by Type

INTERNAL STAFFING	July-Dec 2020	2021	2022	2023
	CLARK COUNTY ONLY			
RN/LPN	1.4	3.6	4.3	4.8
Physical Therapy	1.1	2.6	3.2	3.5
Home Health Aide	0.2	0.4	0.5	0.6
Speech Therapy	0.1	0.3	0.3	0.3
Occupational Therapy	0.4	1.0	1.1	1.3
Medical Social Work	0.1	0.2	0.3	0.3
Administrative / Clerical	0.5	1.0	1.3	1.5
Management / Supervisor	0.0	0.3	0.8	1.0
TOTAL FTE	**3.7**	**9.3**	**11.7**	**13.3**

Source: Providence

2. Please provide your staff to visit ratio.

Please see Table 18 that provides the 2018 staff to visit ratio. The proposed Clark County home health agency will maintain the same staff to visit ratios.

Table 18. Providence Home Health Staff to Visit Ratios, 2018

	Ratio
RN	4.00
LPN	4.75
Physical Therapy	4.00
Home Health Aide	4.75
Speech Therapy	3.25
Occupational Therapy	4.00
Medical Social Work	3.00

Source: Providence

3. Explain how this ratio compares with other national or state standards of care and existing providers for similar services in the proposed service area.

To develop a comparison, Providence reviewed recently approved home health applications and compared those ratios to the ratios provided in Table 15.

Providence found its ratios were consistent with recent home health CN applications.[11]

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

1. Providence Home Health Currently Has Staff Who Reside in Clark County.

Providence Home Health employs more than 400 clinical and administrative staff out of its Portland offices, with a number of staff residing in Clark County. Providence Home Health has the existing infrastructure to begin serving Clark County immediately upon CN approval. Minor administrative and office-based staff are needed to begin service. The care team that is already providing service closest to the border with Clark County can be repositioned to ensure service capacity in Clark County in the early period of operations. For staff who are not already licensed (or in the process of being licensed) in Washington State, Providence intends to pursue the licensure of staff upon CN approval.

2. Providence Health & Services Has Well-Established Human Resource Capabilities

Providence has a strong infrastructure, reputation, and track record for recruiting and retaining personnel. Providence offers a competitive wage scale, a generous benefit package, and a professionally rewarding work setting. Being a large and established provider of health care services, Providence has multiple resources available to assist with the identification and recruitment of appropriate and qualified personnel. These resources include:

- Experienced system and local talent acquisition teams to recruit qualified staff.
- Strong success in recruiting for critical-to-fill positions with recruiters who offer support on a national as well as local level.
- Career listings on the Providence Web site and job listings 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 Nursing Program.

3. Providence Home Health is Successful at Retaining Employees

Providence Home Health currently employs more than 400 staff members and has been highly effective in retaining current staff by offering attractive pay and benefits, maintaining a robust orientation and training program, offering ongoing

[11] Certificate of Need Applications: #17-03, #17-08, #17-36, #18-02

education and development opportunities, engaging staff in Providence's critical mission, and by focusing on retention as a key priority.

With retention as a central strategic priority, Providence Home Health invests heavily in recruiting and retaining the best employees to serve our communities. Providence has an established Employee Training and Development program that includes but is not limited to the following: robust department orientation, clinical and safety training, initial and ongoing competencies assessments, and performance evaluations. Please see Exhibit 23 for a copy of the Employee Training and Development Policy.

5. Please identify, and provide copies of (if applicable) the in-service training plan for staff. (Components of the training plan should include continuing education, home health aide training to meet Medicare criteria, etc.).

Providence Home Health utilizes different venues and processes to ensure all staff receive adequate training, including training to meet Medicare criteria. Providence Home Health training includes, but is not limited to, the following:

- New employee orientation training that addresses employee specific training, job responsibility, quality management, ethical issues, patient rights and responsibilities, confidentiality, HIPAA and Integrity Program, and infection control training. Please see Exhibit 23 for the Employee Training and Development Policy.
- A monthly one-hour in-service training for our Home Health and Hospice Aide Education (2019) that includes modules such as wound care, sepsis, non-compliant patients, mechanical and lift use and safety, and providing care to LGBT clients. Please see Exhibit 24 for the Home Health and Hospice Aide 2019 internal education program. This ongoing education program is updated on an annual basis.
- An annual one- to four-hour nursing skills lab that reviews a rotation of topics including infusion, CADD (infusion) pumps, venipuncture, catheter insertion, and wound care.
- Access to Providence Home Services Clinical Ladder Program. Please see Exhibit 25 for a copy of the Clinical Ladder Handbook.[12]

6. Describe your methods for assessing customer satisfaction and quality improvement.

Providence Home Health has an established Quality Assurance and Performance Improvement ("QAPI") program that employs a number of methods and processes

[12] The Clinical Ladder Program is a system whereby a nurse can demonstrate and be rewarded for excellence in patient care. The Clinical Ladder Program encourages nurses to take the initiative for professional growth and development in their clinical field, thereby enhancing quality of care, patient outcomes, and nursing satisfaction.

in assessing customer satisfaction and quality improvement. The Providence Home Health Manager of Clinical and Quality Education is responsible for facilitating the QAPI program for Providence Home Health. The Manager of Clinical and Quality Education, along with the Home Health Director, Medical Director, Home Health Operation Managers, supervisors, and primary interdisciplinary teams, are responsible for assuring Providence continues to monitor the quality of service it provides and develops performance improvement projects. The Home Services Leadership Council, as delegated by the Governing Body, is responsible for the oversight of the QAPI program. Finally, Providence Home Health instills in its staff that every staff member of our agency has a responsibility in ensuring that we have a robust and effective QAPI program. Please see Exhibit 26 for a copy of the QAPI program.

Providence Home Health has a robust QAPI program. The QAPI program focuses on identifying areas of improvement in patient/family outcomes, process of care, home health services, non-clinical operations, and patient safety. Improvement opportunities are identified and prioritized, including but not limited to: safety, clinical excellence, and improved patient and employee satisfaction. We believe by making quality one of the top focuses at Providence Home Health, the QAPI program has produced notable improvement.

7. Identify your intended hours of operation. In addition, please explain how patients will have access to services outside the intended hours of operation.

The intended hours of operation will be from 8:00 a.m. - 4:30 p.m. daily for regular office hours, with 24/7 access to nursing.

8. Identify and document 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.

Providence Home Health has deep roots in the community and has been providing home health services for more than four decades. Providence Home Health has the capabilities to meet the service demands for the project. Once the project is approved, Providence Home Health will work to make any necessary adjustments or amendments to agreements in order to provide the full spectrum of home health services in Clark County. In cases where the expansion of ancillary services into Clark County is not possible with the existing provider, Providence Home Health will develop new relationships to meet the needs of home health patients in Clark County.

9. Explain 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 service 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.

As an established provider in the community, Providence Home Health works closely with local hospitals, physicians, and other providers to ensure continuity of care, while also avoiding fragmentation. Providence Home Health will leverage its existing relationships, both inside and outside of Clark County, to build additional relationships, as needed, to ensure a full spectrum of care. In cases where Providence Home Health has an existing relationship that does not include Clark County, where applicable Providence Home Health will amend those contracts or agreements to include the new service areas.

Current relationships include but are not limited to the following:

- **Providence Hospitals:** Providence Home Health collaborates closely with all Providence hospitals to support seamless care coordination and continuity from the acute care setting back to the home environment to decrease the likelihood of unnecessary hospital readmissions and enhance the patient and family experience of care.
- **Home Medical Equipment and Specialty Pharmacy Services:** Providence Home Health collaborates closely with both Providence Home Medical Equipment (HME) and Specialty Pharmacy Services to ensure patients are connected and receiving the care and services needed in the home setting.
- **Primary Care Clinics:** Providence Home Health has strong working relationships with Providence Medical Group ("PMG") primary care clinics in Clark County. PMG has a total of four primary care clinics in Clark County, with the first clinic opening in 2009.

Avoiding fragmentation in care delivery is a key reason why Providence is requesting Certificate of Need approval. Providence offers exceptional inpatient and specialty care in the metro Portland service area, such that many Clark County residents seek specialty care in Portland with Providence. As these residents return to their homes, Providence aims to maintain continuity of care ensuring availability of Providence primary care and ambulatory care services and, as care needs change, a seamless transition to home-based and home health services.

Not only does Providence Home Health have strong existing relationships in the community, we recently implemented the Epic Electronic Health Record in our Hospice and Home Health services, which is a very valuable tool to help decrease the risk of fragmentation, improve the quality and timeliness of communication between caregivers, and enhance the overall level of clinical excellence offered.

10. Fully describe any history of the applicant entity and principles in Washington with respect to criminal convictions, denial or revocation of license to operate a health care facility, revocation of license to practice a health profession, or decertification as a provider of services in the Medicare or Medicaid program. 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.

a. Have any of the applicants been adjudged insolvent or bankrupt in any state or federal court?

b. Have any of the applicants been involved in a court proceeding to make judgment of insolvency or bankruptcy with respect to the applicant).

There are no such convictions or denial or revocation of licenses, so this question is not applicable.

11. List the licenses and/or credentials held by the applicant(s) and principles in Washington, as well as other states, if applicable. Include any applicable license numbers.

- Providence Home Health is currently licensed as a Washington in Home Services Agency, with license # IHS.FS.60108399.
- Providence Home Health is currently licensed as a Medicare certified agency through Oregon State accreditation, with license number 38-7048.
- Providence Home Health's Oregon Medicaid license number is 241348.
- Providence Home Health is accredited with The Joint Commission, with accreditation number 320680.

12. Provide the background experience and qualifications of the applicant(s).

Providence was one of the early providers of health care services when the Sisters of Providence came to Vancouver in the 1850s. More than a century later, Providence continues to provide services to everyone, regardless of age, ethnicity, gender, or ability to pay, with a special focus on providing care to the poor and vulnerable in our community. Over the years, Providence Home Health has grown and provides a full complement of clinical staff, including Registered Nurses, Physical Therapist, Occupational Therapist, Speech and Language Therapists, Social Workers, and Home Health Aides.

As the demographics of our community have changed, Providence has responded to these needs by developing new resources. For example, Providence has developed specialty teams, such as Palliative Care, Mental Health Nursing, and Speech Language Therapist with special training in augmentative communication for the most vulnerable patients who have no other means of communicating their

most basic needs. Providence continues to assess the needs of the community and develop new and innovative ways to meet those needs.

Providence Home Health currently serves patients in Clackamas, Clatsop, Columbia, Hood River, Marion, Multnomah, Polk, Tillamook, Wasco, Washington, and Yamhill. Providence Home Health provides more than 240,000 patients visits annually and approximately 12,000 unique patients annually across Northern Oregon and Southwest Washington. Providence Home Health in Oregon employs approximately 400 clinical and administrative staff.

Providence Home Health has remained a leader in the industry and actively participates in the Oregon State Association for Home Care, the Washington State Association for Home Care, and the National Association for Home Care.

- Our Director of Home Health (Susan Murtha, RN, MBA) is a registered nurse with 30 years' experience, including 19 years of clinical experience in home health nursing. Ms. Murtha has more than 15 years' experience in management and executive roles. Ms. Murtha is licensed in Oregon and would seek licensure in Washington upon CN approval. Please see Exhibit 27 for a copy of Ms. Murtha's Oregon credentials.
- Our Chief of Home Health, WA and OR, Nancy Rickerson, Ph.D., OTR/L, has 38 years of clinical experience with 12 years of home health experience and multidisciplinary clinical leadership. She received her doctorate in organization and educational leadership and policy. Please see Exhibit 28 for a copy of Ms. Rickerson's Washington provider credentials.
- Our Medical Director (Ruth Medak, MD) is a Doctor of Medicine with more than 35 years of experience and has served as Medical Director for Providence since 2012. Dr. Medak is board certified in Internal Medicine and is board certified in Hospice and Palliative Medicine. Please see Exhibit 7 for a copy of Dr. Medak's Oregon Provider Credentials.

Providence, more generally, has deep roots in the broader community, offering an array of services. In Oregon alone, Providence has eight acute care settings, 48 primary care locations, 143 specialty clinic locations, and well-established home health and hospice agencies, as well as numerous urgent care locations. In Clark County, Providence has four primary care clinics (including specialties such as cardiology, gastroenterology, occupational health, podiatry, and behavioral health services), and one urgent clinic.

Providence has established strong relationships in the Clark County community, both in the health delivery sector as well as with community support organizations. We are proud to support many organizations in the community that have a mission in caring for the poor and the vulnerable, which is in alignment with the Providence mission. Some of these organizations include: Share House, YMCA, Free Clinic

of Southwest Washington, Children's Center, CDM Caregiving Services, Evergreen Habitat for Humanity, and the Council for the Homeless.

As noted above, Providence employs a state-of-the art-Epic Electronic Health Record ("EHR") system, having established Epic in most care settings, including recently bringing Providence Home Health onto the same Epic instance. This is a notable differentiator in the home health care space. This places Providence Home Health in a position to ensure continuity of care, avoidance of unnecessary duplication of services, opportunities to improve quality of care, and improved communication among providers and also between providers and patients. Epic allows one chart to follow the patient through the continuum of care.

13. For <u>existing agencies</u>, provide copies of the last three licensure surveys as appropriate evidence that services will be provided (a) in a manner that ensures safe and adequate care, and (b) in accordance with applicable federal and state laws, rules, and regulations.

The three most recent surveys include the 2016 Washington Department of Health survey, the 2017 Oregon Health Authority survey, and the 2019 Joint Commission survey. Please see Exhibit 29 for the most recent three licensure surveys.

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

1. Identify the exploration of alternatives to the project you have chosen to pursue, including postponing action, shared service arrangements, joint ventures, subcontracting, 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 (cost limits, availability, quality of care, legal restriction, etc.):**
- **Advantages and disadvantages, and whether the sum of either the advantages or the disadvantages outweighs each other by application of the decision-making criteria;**
- **Capital costs;**
- **Staffing impact.**

Providence Home Health is requesting CN approval to operate a Medicare and Medicaid certified home health agency in Clark County in Washington. The home health agency will be based out of Providence Home Health's Portland office located in Washington County. Operating a new agency will help address the unmet need for home health care in Clark County.

As part of its due diligence, and in deciding to submit this application, Providence Home Health explored the following alternatives: (1) status quo: "do nothing or postpone action," (2) the requested project: seek CN approval for a home health agency, (3) partner and create a joint venture and seek CN approval for a home health agency.

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 a new home health agency in Clark County.

Table 19. 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. (D)

	The principal disadvantage is that the status quo does nothing to address the quantitative need for an additional home health agency in Clark County. Consequently, it does not address access to care issues that currently exist. (D)
Requested Project: seek CN approval for a home health agency	The requested project addresses current and future access issues identified in Clark County. (A) From an improved access perspective, there are no disadvantages. (A)
Create a joint venture for a new home health agency	Depending on the partnership, this alternative would have the potential to meet current and future access issues identified in Clark County. (A) Partnering with another entity should not adversely impact access to services under the assumption that the project would remain similar to the proposed project. (N)

Table 20. 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 the impact on quality of care as it relates to timeliness. Access to care in a timely fashion is linked directly to clinical quality outcomes, including metrics like readmissions and unnecessary hospital utilization. (D)
Requested Project: seek CN approval for a home health agency	The requested project meets and promotes quality and continuity of care in Clark County. (A)
Create a joint venture for a new home health agency	Partnering with another entity will not likely adversely impact quality of care when compared to the proposed project, although it adds additional layers of operational complexity. (N)

Table 21. Alternative Analysis: Cost and Operating Efficiency

Option	Advantages/Disadvantages
Status Quo: "Do nothing"	With this option, there would be no impacts on costs. (N) The principal disadvantage is that by maintaining the status quo, there are no improvements to cost efficiencies. (D)
Requested Project: seek CN approval for a home health agency	This option allows Providence Home Health to better utilize and leverage fixed costs, and spread those fixed costs over a larger service area and set of services. (A) From a cost and operational efficiency perspective, the project may incur minimal operating expense losses in the early startup period before it reaches sufficient volume to cover fixed and variable costs. (N)
Create a joint venture for a new home health agency	Partnering with another entity will likely decrease the overall start up operating losses that Providence Home Health may face. But if there are operating losses in the first year, there is no reason to believe they would be less under a joint venture (N). A partnership would increase operating complexity and may add other partnership-related costs. In this scenario, costs may increase due additional efforts required to establish the governance and ownership structure, establish a new staffing structure, and accommodate partner preferences on how to deliver care. (D)

Table 22. Alternative Analysis: Staffing Impacts

Option	Advantages/Disadvantages
Status Quo: "Do nothing"	The principal advantage is the avoidance of hiring/employing additional staff. (A) There are no disadvantages from a staffing point of view. (N) This option will not add to community job growth and economic development. (D)

Requested Project: seek CN approval for a home health agency	This option creates new jobs, which benefits Clark County and provides opportunities for the specialization of staff dedicated to efficient delivery of home health services. (A) From a staffing impacts perspective, there are no disadvantages as Providence Home Health has a solid track record of being able to hire and retain high quality staff. (N)
Create a joint venture for a new home health agency	Partnering with another entity would create less staffing flexibility from the perspective of Providence Home Health. In this scenario, Providence Home Health would have to build and establish additional management processes and structures, and may have to negotiate new compensation benefit packages for clinical staff. (D)

Table 23. Alternative Analysis: Legal Restrictions

Option	Advantages/Disadvantages
Status Quo: "Do nothing"	There are no legal restrictions to continuing present operations. (A)
Requested Project: seek CN approval for a home health agency	From a legal restrictions perspective, there are no advantages. (N) The principal disadvantage is that it requires CN approval, which requires time and expense. (D)
Create a joint venture for a new home health agency	Partnering with another entity introduces a high degree of operational complexity, as under this scenario, a completely new governance structure would have to be established along with obtaining agreement on operational processes. (D) The principal disadvantage is that it requires CN approval, which requires time and expense. (D)

2. Describe how the proposal will comply with the Medicare conditions of participation, without exceeding the costs caps.

As a not-for-profit entity, Providence takes seriously the effective stewardship and management of not only its own resources, but also resources from payers and entities such as CMS.

Since home health agencies are not subject to Medicare cost caps, this question is not applicable.

3. Describe the specific ways in which the project will promote staff or system efficiency or productivity.

The requested project responds to a clear, demonstrated quantitative need in Clark County. The proposed home health agency will allow Providence Home Health to redeploy employees already based in Clark County to serve patients who are in need of home health services.

Furthermore, as an integrated health care delivery system, coordinating care transitions between internal Providence caregivers (i.e. from Providence physicians based in Clark County or from Providence hospitals in Oregon for patients returning home to Clark County) will streamline communication channels and expedite access to care. As a not-for-profit entity, any savings or margin Providence Home Health makes can be allocated back toward patient care.

Home health promotes efficiency as it shifts care from expensive hospital settings to lower cost, home-based settings. For patients who choose home health, they may forgo more expensive curative treatments and seek the best possible care experience focused on personalized care plans. Finally, home health promotes efficiency by reducing both hospital readmission and preventable ER visits.

4. If applicable, 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 cost for each proposed service. Reference appropriate recognized space planning guidelines you have employed in your space allocation activities.

This question is not applicable, as there is no construction, renovation, or expansion involved in the project.

5. If applicable, 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.

This question is not applicable, as there is no construction, renovation, or expansion involved in the project.

Exhibit 1
Check to DOH

Exhibit 2
Letter of Intent

PROVIDENCE
Health & Services

October 23, 2019

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

RE: Letter of Intent: Providence Health & Services-Oregon d/b/a Providence Home Health, Medicare and Medicaid Certified Home Health Agency

Dear Ms. Tyson:

In accordance with WAC 246-310-080, Providence Health & Services-Oregon d/b/a Providence Home Health ("Providence Home Health") respectfully submits this Letter of Intent to operate a Medicare and Medicaid Certified Home Health Agency to serve residents of Clark County.

1. Description of proposed service
   Providence Home Health requests Certificate of Need approval to operate a Medicare and Medicaid Certified Home Health Agency.

2. Estimated cost of the project
   There are no capital costs associated with the proposed project.

3. Identification of the service area
   The agency will serve Clark County.

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

Sarah Cameron, Vice President, Strategy and Planning
Providence Home and Community Care
2811 South 102nd St, Suite 220
Tukwila, WA 98168

and

Lisa Crockett, Executive Director, Strategy & Planning
Providence Health & Services
7515 Terminal St SW
Tumwater, WA 98501

Thank you for your assistance in this matter. Please contact me if you have any questions.

Sincerely,

Sarah Cameron
Vice President, Strategy and Planning
Providence Home and Community Care

Exhibit 3
PSJH Legal Structure

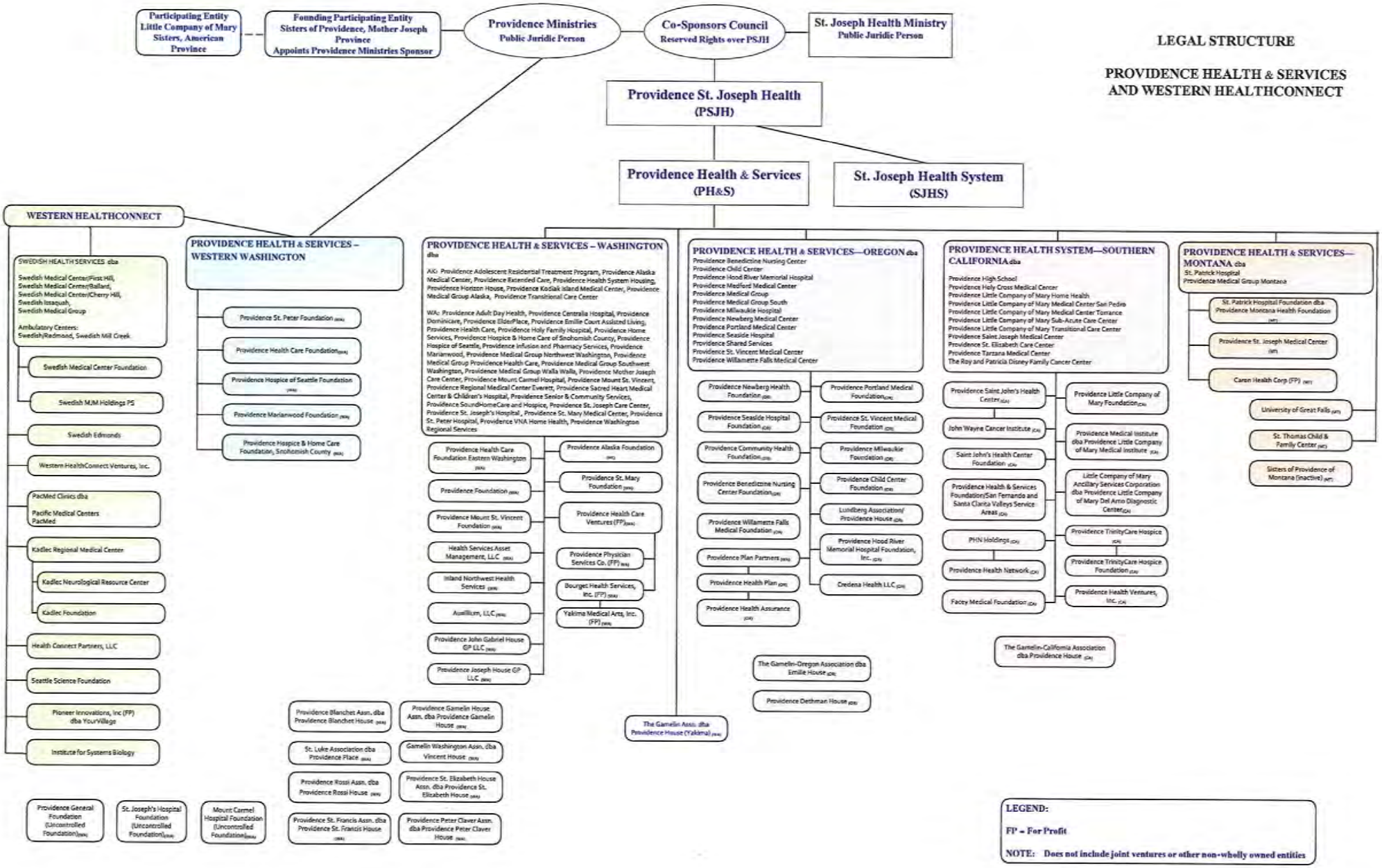
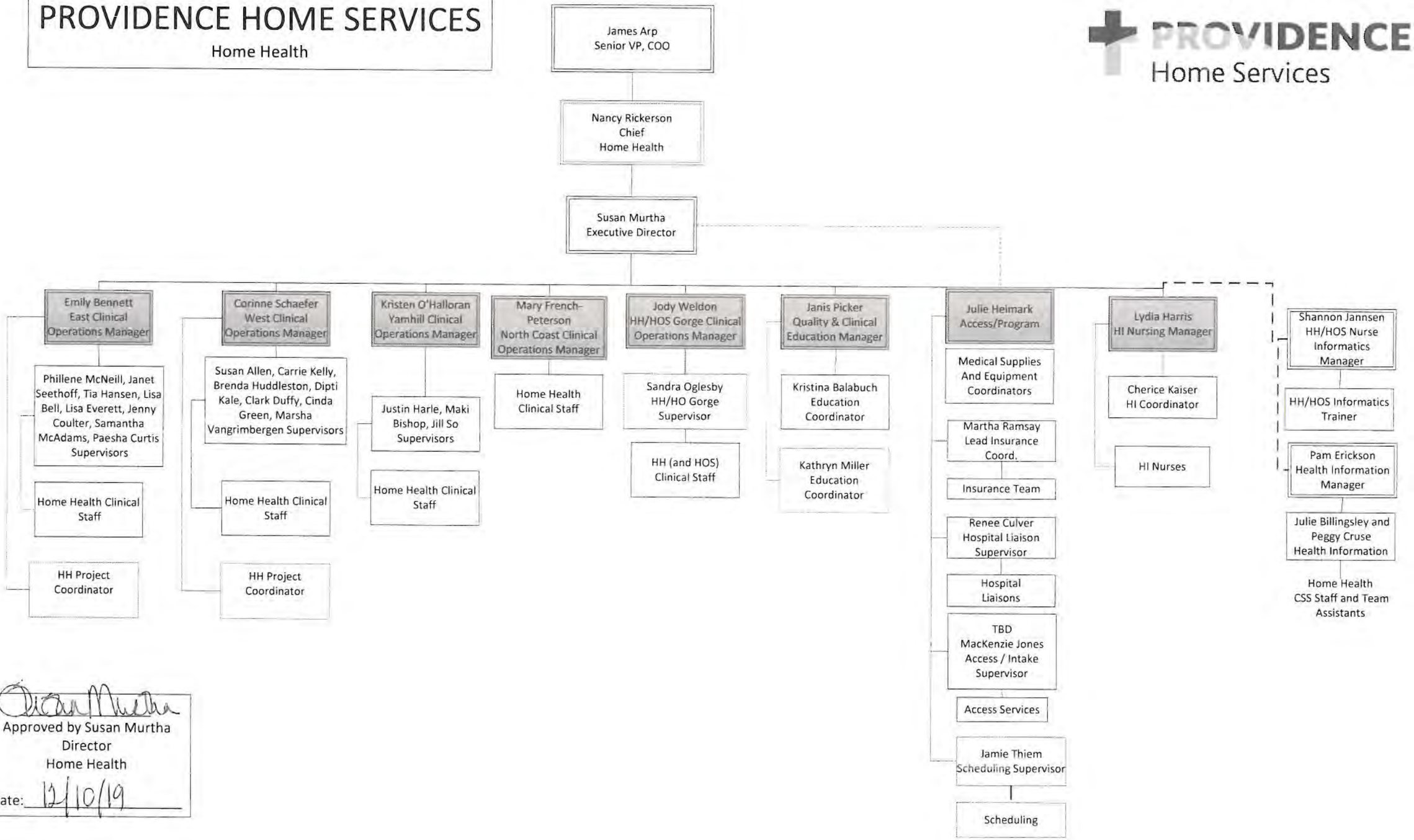

Participating Entity
Little Company of Mary Sisters, American Province
Founding Participating Entity
Sisters of Providence, Mother Joseph Province
Appoints Providence Ministries Sponsor
Providence Ministries
Public Juridic Person
Co-Sponsors Council
Reserved Rights over PSJH
St. Joseph Health Ministry
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
Providence Home Health Organizational Chart

PROVIDENCE HOME SERVICES

Home Health

PROVIDENCE
Home Services



Approved by Susan Murtha
Director
Home Health

Date: 12/10/19

Exhibit 5
Oregon Health Authority Business License

Oregon Health Authority

Health Care Regulation and Quality Improvement
800 NE Oregon Street, Suite 465
Portland, Oregon 97232
971-673-0540
971-673-0556 (Fax)

August 16, 2019

Ms. Susan Murtha, Rn/lpn
Providence Home Health
6410 NE Halsey Street, Suite 200
Portland, OR 97213

Re: Your Facility License, 13-1392

Dear Ms. Murtha:

The updated license reflecting the addition of a branch location for your facility, Providence Home Health, is enclosed. The license is effective August 16, 2019.

It is valid until December 31, 2019 and will need to be renewed prior to the expiration date. We will send you a renewal notice 60 days prior to expiration of the license.

Please feel free to contact us at any time if you have questions. You may contact this office at (971) 673-0540.

Sincerely,

Lisa Humphries
Oregon Health Authority
Public Health Division
Health Care Regulation and Quality Improvement

If you need this information in an alternate format, please call our office at (971) 673-0540 or TTY 711

Dear Providers,

As a reminder please post your license in a conspicuous location in your facility.

- *Satellite Location licenses need to be posted at the physical satellite location.*

DMAP providers, please fax a copy of your license to 503-947-1177

If you see any mistakes or have any questions regarding your license please contact 971-673-0540.

Thank you very much,
Health Care Regulation and Quality Improvement Staff

AUDIT# 405100

OREGON HEALTH AUTHORITY PUBLIC HEALTH DIVISION

HEALTH CARE FACILITY

13-1392
LICENSE NUMBER

December 31, 2019
EXPIRATION DATE
MO DAY YR

Class: **HHA**
Services/Cap: SN, HHA, PT, OT, ST, MSS
Branches: 6

Providence Health & Services-Oregon
DBA Providence Home Health
6410 NE Halsey Street, Suite 200
Portland, OR 97213

Issued: 08/16/2019

MUST BE POSTED IN A CONSPICUOUS PLACE – NOT TRANSFERABLE

03/11

Exhibit 6
Providence Facilities with Post-Acute Care Services

Providence Facilities with Post-Acute Care Services

Service Line	Name	Address	City	State	Zip
Assisted Living Facility	Providence Forest View Assisted Living	3831 Piper St Suite S-333	Anchorage	Alaska	99508
Assisted Living Facility	Providence Heritage House at the Market	1533 Western Ave	Seattle	Washington	98101
Assisted Living Facility	Providence Mount St. Vincent Assisted Living	4831 35th Ave SW	Seattle	Washington	98126
Assisted Living Facility	Providence St. Joseph Assisted Living Center	11 17th Ave East	Polson	Montana	59860
Assisted Living Facility	Providence Emilie Court Assisted Living	34 E 8th Ave	Spokane	Washington	99202
Assisted Living Facility	Providence Horizon House	4140 Folker St	Anchorage	Alaska	99508
Assisted Living Facility	Providence Brookside Manor	1550 Brookside Dr	Hood River	Oregon	97031
Assisted Living Facility	Providence Irvington Village	420 NE Mason St	Portland	Oregon	97211
Assisted Living Facility	Providence Benedictine Orchard House Personalized Living Center	550 S Main St	Mt. Angel	Oregon	97362
Behavioral Health	Providence Adolescent Residential Treatment Center	3200 Providence Dr	Anchorage	Alaska	99508
Behavioral Health	Providence Kodiak Island Counseling Center	1915 East Rezanof Dr	Kodiak Island	Alaska	99615
Behavioral Health	Providence Crisis Recovery Center	3200 Providence Dr	Anchorage	Alaska	99508
Behavioral Health	Providence Valdez Counseling Center	911 Meals Ave	Valdez	Alaska	99686
Home Care Agency	Providence DominiCare	110 S 3rd St East	Chewelah	Washington	99109
Home Care Agency	Nurse Next Door (Orange)	200 W Center Street Promenade, Suite 200	Anaheim	California	92805
Home Care Agency	Nurse Next Door (Corona)	1315 Corona Pointe Ct #201	Corona	California	92879
Home Health	Providence Home Health - Portland (West Portland)	10126 SW Park Way	Portland	Oregon	97225
Home Health	Providence Home Health - Portland (Yamhill)	1515 Portland Rd, Suite 102	Newberg	Oregon	97132
Home Health	Providence Home Health - Portland (Gorge)	1630 Woods Court	Hood River	Oregon	97031
Home Health	Providence Home Health - Portland (North Coast)	3605 Highway 101 North	Seaside	Oregon	97138
Home Health	Providence Home Health - Portland (East Portland)	9936 SE Washington St, Suite E-10	Portland	Oregon	97216
Home Health	Providence Little Company of Mary Home Health	5315 Torrance Blvd, Suite B1	Torrance	California	90503
Home Health	Providence Home Services, Southern Oregon - Providence Home Health	2033 Commerce Drive	Medford	Oregon	97504
Home Health	Providence Benedictine Home Health	570 S Main St	Mt. Angel	Oregon	97362
Home Health	Providence Hospice and Home Care of Snohomish County (Home Health)	2731 Wetmore, Suite 500	Everett	Washington	98201
Home Health	Providence Home Services King County	2811 S 102nd St, Suite 220	Tukwila	Washington	98168
Home Health	Providence VNA Home Health	1000 N Argonne Rd	Spokane Valley	Washington	99212
Home Health	Providence St. Mary Home Health	209 W Poplar St	Walla Walla	Washington	99362
Home Health	St. Joseph Home Care - Sonoma County	439 College Ave	Santa Rosa	California	95401
Home Health	St. Joseph Home Health Queen of the Valley	980 Trancas Street Suite 9	Napa	California	94558
Home Health	St. Joseph Home Care - Humboldt County	2127 Harrison Ave	Eureka	California	95501
Home Health	St. Joseph Home Care Services	200 W Center Street Promenade, Suite 200	Anaheim	California	92805
Home Health	Sea Crest Home Health Services	3187 Redhill, Suite 200	Costa Mesa	California	92626
Home Health	St. Mary High Desert	17081 Main Street	Hesperia	California	92345
Home Health	Providence SoundHomeCare & Hospice (Home Health)	4200 6th Ave SE, Suite 201	Lacey	Washington	98503
Home Health	St. Joseph Medical Center Home Health	3413 W Pacific Ave	Burbank	California	91505
Home Health	Providence In-Home Services (Home Health)	4001 Dale Street, Suite 101	Anchorage	Alaska	99508
Home Health	North Star Healthcare Home Health	3201 W Temple Ave, Suite 200	Ponoma	California	91768
Home Health	St. Joseph Mission Viejo branch	26522 La Alameda	Mission Viejo	California	92691
Home Health	Providence Benedictine Home Health (Salem)	2520 Pringle Rd SE	Salem	Oregon	97302
Home Medical Equipment	Providence Home Medical Equipment - Salem	2508 SE Pringle Rd	Salem	Oregon	97302
Home Medical Equipment	Providence Home Medical Equipment - Portland	6410 NE Halsey St	Portland	Oregon	97213
Home Medical Equipment	Providence Infusion and Home Medical Equipment - Medford	840 Royal Ave, Suite 120	Medford	Oregon	97504
Hospice	Providence Hospice of Seattle	2811 S 102nd St, Suite 220	Tukwila	Washington	98168
Hospice	Providence Hospice and Home Care of Snohomish County (Hospice)	2731 Wetmore, Suite 500	Everett	Washington	98201
Hospice	Providence Hospice - Portland (West Branch)	10126 SW Park Way	Portland	Oregon	97225
Hospice	Providence Hospice - Portland (Gorge Branch)	1630 Woods Court	Hood River	Oregon	97031
Hospice	Providence Home Services, Southern Oregon - Providence Hospice	2033 Commerce Drive	Medford	Oregon	97504
Hospice	Providence Benedictine Hospice	580 S Main St	Mt. Angel	Oregon	97362
Hospice	Providence Hospice - Portland (East Branch)	9936 SE Washington St, Suite E-10	Portland	Oregon	97216
Hospice	St. Joseph Health North County Hospice	205 East St	Healdsburg	California	95448
Hospice	St. Joseph Health Memorial Hospice	439 College Ave	Santa Rosa	California	95401
Hospice	St. Joseph Health Hospice of Petaluma	416 Payran St	Petaluma	California	94954
Hospice	St. Joseph Hospice	200 W Center Street Promenade, Suite 200	Anaheim	California	92805
Hospice	Sea Crest Hospice	3187 Red Hill Ave, Suite 230A	Costa Mesa	California	92626
Hospice	Providence TrinityCare (Torrance)	5315 Torrance Blvd	Torrance	California	90503
Hospice	Providence SoundHomeCare & Hospice (Hospice)	4200 6th Ave SE, Suite 201	Lacey	Washington	98503
Hospice	Hospice of Lubbock	3702 21st St	Lubbock	Texas	79410
Hospice	Providence TrinityCare (Cerritos)	17315 Studebaker Rd, Suite 101	Cerritos	California	90703
Hospice	Providence In-Home Services (Hospice)	4001 Dale Street, Suite 101	Anchorage	Alaska	99508
Hospital	Providence Newberg Medical Center	1001 Providence Dr	Newberg	Oregon	97132
Hospital	Providence Milwaukie Medical Center	10150 SE 32nd Ave	Milwaukie	Oregon	97222
Hospital	Providence Medford Medical Center	1111 Crater Lake Ave	Medford	Oregon	97504
Hospital	Providence Willamette Falls Medical Center	1500 Division St	Oregon City	Oregon	97045
Hospital	Providence Portland Medical Center	4805 NE Glisan St	Portland	Oregon	97213
Hospital	Providence Seaside Hospital	725 S Wahanna Rd	Seaside	Oregon	97138
Hospital	Providence Hood River Memorial Hospital	810 12th St, PO Box 149	Hood River	Oregon	97031
Hospital	Hoag Hospital Newport Beach	1 Hoag Dr	Newport Beach	California	92663
Hospital	Queen of the Valley Medical Center	1000 Trancas St	Napa	California	94558
Hospital	Providence St. Vincent Medical Center	9205 SW Barnes Rd	Portland	Oregon	97225
Hospital	St. Jude Medical Center	101 East Valencia Mesa Dr	Fullerton	California	92835
Hospital	Providence Sacred Heart Children's Hospital	101 West 8th Ave	Spokane	Washington	99204
Hospital	Providence Sacred Heart Medical Center	101 West 8th Ave	Spokane	Washington	99204
Hospital	St. Joseph Hospital, Orange	1100 West Stewart Dr	Orange	California	92868
Hospital	Santa Rosa Memorial Hospital	1165 Montgomery Dr	Santa Rosa	California	95405
Hospital	Providence Little Company of Mary Medical Center San Pedro	1300 W 7th St	San Pedro	California	90503
Hospital	Providence Holy Cross Medical Center	15031 Rinaldi St	Mission Hills	California	91345
Hospital	Hoag Hospital Irvine	16200 Sand Canyon Ave	Irvine	California	92618
Hospital	Hoag Orthopedic Institute	16250 Sand Canyon Ave	Irvine	California	92618
Hospital	Providence Regional Medical Center Everett	1700 13th St	Everett	Washington	98201

Hospital	St. Mary Medical Center	18300 Highway 18	Apple Valley	California	92307
Hospital	Providence Tarzana Medical Center	18321 Clark St	Tarzana	California	91356
Hospital	Covenant Hospital Levelland	1900 College Ave	Levelland	Texas	79336
Hospital	Providence Kodiak Island Medical Center	1915 East Rezanof Dr	Kodiak Island	Alaska	99615
Hospital	Providence Saint John's Health Center	2121 Santa Monica Blvd	Santa Monica	California	90404
Hospital	Swedish Medical Center, Edmonds Campus	21601 76th Ave W	Edmonds	Washington	98026
Hospital	Covenant Health Plainview	2601 Dimmit Rd	Plainview	Texas	79072
Hospital	St. Joseph Hospital, Eureka	2700 Dolbeer St	Eureka	California	95501
Hospital	Mission Hospital Mission Viejo	27700 Medical Center Rd	Mission Viejo	California	92691
Hospital	Mission Hospital Laguna Beach	31872 Coast Hwy	Laguna Beach	California	92651
Hospital	Providence Alaska Medical Center	3200 Providence Dr	Anchorage	Alaska	99508
Hospital	Redwood Memorial Hospital	3300 Renner Dr	Fortuna	California	95540
Hospital	Covenant Medical Center	3615 19th St	Lubbock	Texas	79410
Hospital	Covenant Specialty Hospital	3815 20th St	Lubbock	Texas	79410
Hospital	Petaluma Valley Hospital	400 N McDowell Blvd	Petaluma	California	94954
Hospital	Covenant Children's Hospital	4002 24th St	Lubbock	Texas	79410
Hospital	Providence St. Mary Medical Center	401 W Poplar St	Walla Walla	Washington	99362
Hospital	Providence Little Company of Mary Medical Center Torrance	4101 Torrance Blvd	Torrance	California	90503
Hospital	Providence St. Peter Hospital	413 Lilly Road NE	Olympia	Washington	98506
Hospital	Providence Seward Medical and Care Center	417 1st Ave	Seward	Alaska	99664
Hospital	Swedish Medical Center, Cherry Hill Campus	500 17th Ave	Seattle	Washington	98122
Hospital	Providence St. Joseph's Hospital	500 E Webster	Chewelah	Washington	99109
Hospital	Providence St. Patrick Hospital	500 W Broadway	Missoula	Montana	59802
Hospital	Providence Saint Joseph Medical Center	501 S Buena Vista St	Burbank	California	91505
Hospital	Swedish Medical Center, Ballard Campus	5300 Tallman Ave NW	Seattle	Washington	98107
Hospital	Providence Holy Family Hospital	5633 N Lidgerwood St	Spokane	Washington	99208
Hospital	Providence St. Joseph Medical Center	6 13th Ave East	Polson	Montana	59860
Hospital	Swedish Medical Center, First Hill Campus	747 Broadway	Seattle	Washington	98122
Hospital	Swedish Medical Center, Issaquah Campus	751 NE Blakely Dr	Issaquah	Washington	98029
Hospital	Kadlec Regional Medical Center	888 Swift Blvd	Richland	Washington	99352
Hospital	Providence Valdez Medical Center	911 Meals Ave	Valdez	Alaska	99686
Hospital	Providence Centralia Hospital	914 S Scheuber Rd	Centralia	Washington	98531
Hospital	Providence Mount Carmel Hospital	982 E Columbia Ave	Colville	Washington	99114
Housing - Other	Providence Down Manor	1950 Sterling Place	Hood River	Oregon	97031
Infusion	Providence Home Infusion (West)	10140 SW Park Way	Portland	Oregon	97225
Infusion	Providence Home Infusion (Salem)	2508 Pringle Rd SE	Salem	Oregon	97302
Infusion	Providence Home Infusion (East)	6410 NE Halsey St	Portland	Oregon	97213
Infusion	Humboldt Home Infusion	2612 Harrison Ave	Eureka	California	95501
Infusion	Pharmacy Infusion (St. Joseph Home Care Services)	200 W Center Street Promenade, Suite 200	Anaheim	California	92805
Infusion	Providence Infusion and Pharmacy Services - East	10807 E Montgomery, Suite 8	Spokane Valley	Washington	99206
Infusion	Providence Infusion and Pharmacy Services - West	3333 S 120th Pl, Suite 100	Tukwila	Washington	98168
Infusion	Covenant Home Infusion	4002 22nd Pl	Lubbock	Texas	79410
Infusion	Providence Infusion and Home Medical Equipment - Medford	840 Royal Ave, Suite 120	Medford	Oregon	97504
Infusion (AIS)	Providence Infusion & Pharmacy Services - Renton	2201 Lind Ave SW, Suite 130	Renton	Washington	98057
Infusion (AIS)	Providence Infusion & Pharmacy Services - Pacific Campus	916 Pacific Ave, Suite S1-011	Everett	Washington	98201
Infusion (AIS)	Providence Infusion & Pharmacy Services - Seattle	Swedish First Hill Campus - Nordstrom Tower, 1229 Madison St, Suite 1220	Seattle	Washington	98104
Other	Providence Transitions Program	2811 S 102nd St	Tukwila	Washington	98168
Other	Providence Regina House	8201 10th Ave S #6	Seattle	Washington	98108
Other	Providence Mount St. Vincent Intergenerational Learning Center	4831 35th Ave SW	Seattle	Washington	98126
Other	Optimal Aging	800 5th Ave	Seattle	Washington	98104
Other	Providence Connections	4001 Dale Street, Suite 101	Anchorage	Alaska	99508
Other	Providence Nurse-Family Partnership	3760 Piper St, Suite 1080	Anchorage	Alaska	99508
PACE	Providence ElderPlace Seattle	4515 Martin Luther King Jr Way, Suite 100	Seattle	Washington	98108
PACE	Providence ElderPlace West Seattle	4831 35th Ave SW	Seattle	Washington	98126
PACE	Providence ElderPlace Kent	7829 S 180th St	Kent	Washington	98032
PACE	Providence ElderPlace Redmond	8632 160th Ave NE	Redmond	Washington	98052
PACE	Providence ElderPlace Milwaukie	10330 SE 32nd Ave, Suite 110	Milwaukie	Oregon	97222
PACE	Providence ElderPlace in North Coast	1150 N Roosevelt Dr, Suite 104	Seaside	Oregon	97138
PACE	Providence ElderPlace Glendoveer	13007 NE Glisan St	Portland	Oregon	97230
PACE	Providence ElderPlace Gresham	17727 E Burnside St	Portland	Oregon	97233
PACE	Providence ElderPlace Beaverton	18650 NW Cornell Rd, Suite 215	Hillsboro	Oregon	97124
PACE	Providence ElderPlace Irvington Village	420 NE Mason St	Portland	Oregon	97211
PACE	Providence ElderPlace Laurelhurst	4540 NE Glisan St	Portland	Oregon	97213
PACE	Providence ElderPlace at The Marie Smith Health and Social Center	4616 N Albina	Portland	Oregon	97217
PACE	Providence ElderPlace Cully	5119 NE 57th Ave	Portland	Oregon	97218
Skilled Nursing Facility	Providence Little Company of Mary Medical Center San Pedro Sub Acute Care	1300 W 7th St	San Pedro	California	90503
Skilled Nursing Facility	Providence Little Company of Mary Transitional Care Center	4320 Maricopa St	Torrance	California	90503
Skilled Nursing Facility	Providence Holy Cross Medical Center Sub Acute Care	15031 Rinaldi St	Mission Hills	California	91345
Skilled Nursing Facility	Providence Mount St. Vincent	4831 35th Ave SW	Seattle	Washington	98126
Skilled Nursing Facility	Providence Mother Joseph Care Center	3333 Enisgn Rd NE	Olympia	Washington	98506
Skilled Nursing Facility	Providence Marianwood	3725 Providence Point Dr SE	Issaquah	Washington	98029
Skilled Nursing Facility	Providence St. Joseph Care Center	17 E 8th Ave	Spokane	Washington	99202
Skilled Nursing Facility	Providence St. Joseph's Hospital - TCU	500 E Webster	Chewelah	Washington	99109
Skilled Nursing Facility	Providence St. Elizabeth Care Center	10425 Magnolia Blvd	North Hollywood	California	91601
Skilled Nursing Facility	Providence Extended Care	920 Compassion Cir	Anchorage	Alaska	99504
Skilled Nursing Facility	Providence Transitional Care Center	910 Compassion Cir	Anchorage	Alaska	99504
Skilled Nursing Facility	Providence Seward Mountain Haven	2203 Oak St, PO Box 430	Seward	Alaska	99664
Skilled Nursing Facility	Providence Chiniak Bay Elder House	1915 East Rezanof Dr	Kodiak Island	Alaska	99615
Skilled Nursing Facility	Providence Valdez Extended Care Center	911 Meals Ave	Valdez	Alaska	99686
Skilled Nursing Facility	Providence Benedictine Nursing Center	540 S Main St	Mt. Angel	Oregon	97362
Supportive Housing	Providence Peter Claver House	7101 38th Ave S	Seattle	Washington	98118
Supportive Housing	Providence Vincent House	1423 First Ave	Seattle	Washington	98101
Supportive Housing	Providence Joseph House	11215 5th Ave SW	Seattle	Washington	98146

Supportive Housing	Providence Gamelin House	4515 Martin Luther King Jr Way	Seattle	Washington	98108
Supportive Housing	Booth Gardens Apartments	9722 8th Ave NW	Seattle	Washington	98117
Supportive Housing	Providence Elizabeth House	3201 Graham St SW	Seattle	Washington	98126
Supportive Housing	Providence Blanchet House	1700 Providence Lane	Centralia	Washington	98531
Supportive Housing	Providence Rossi House	1700 Providence Lane	Centralia	Washington	98531
Supportive Housing	Providence St. Francis House	3415 12th Ave NE	Olympia	Washington	98506
Supportive Housing	Providence Place	350 Washington Ave	Chehalis	Washington	98532
Supportive Housing	Providence John Gabriel House	8632 160th Ave NE	Redmond	Washington	98052
Supportive Housing	Providence House - Yakima	312 N Fourth St	Yakima	Washington	98901
Supportive Housing	Providence House - Oakland	540 23rd St	Oakland	California	94612
Supportive Housing	Providence Hickel House	3967 Piper Dr	Anchorage	Alaska	99508
Supportive Housing	Providence Dethman House	1250 Montello Ave	Hood River	Oregon	97031
Supportive Housing	Providence Emilie House	5520 NE Glisan	Portland	Oregon	97213
Supportive Housing	Providence House - Portland	5921 E Burnside	Portland	Oregon	97215

Exhibit 7
Medical Director Provider Credentials

Medical Director Provider Credentials

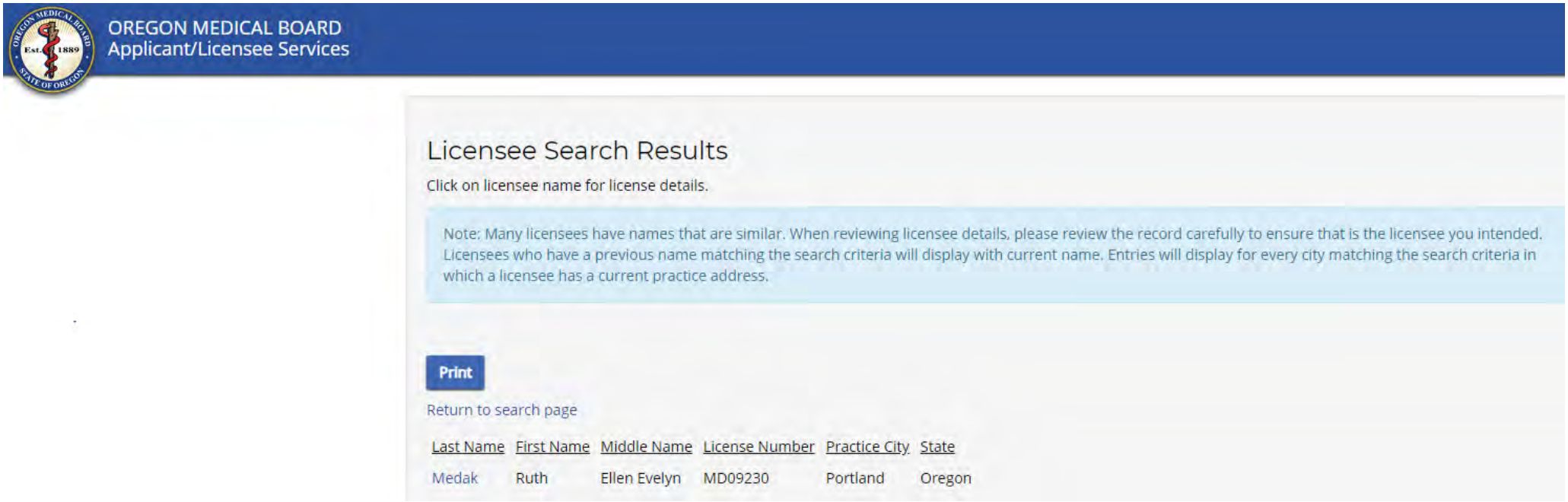


Exhibit 8
Medical Director Job Description

Position Title:	Medical Director	**Reports To:**	CEO, Administrator, CMO, CNE
Position Type:	Manager		
Date Developed:	02/17		

MISSION, CORE VALUES AND VISION:

Mission:
As people of Providence, we reveal God's love for all, especially the poor and vulnerable, through our compassionate service.

Core Values:
As a member of the Providence team, you will work in a mission-driven environment that encourages diversity and personal growth and fosters our core values of Respect, Compassion, Justice, Excellence, and Stewardship.

Vision:
As people of Providence, we will provide a *connected experience of care* built on a foundation of clinical excellence.

General Summary:
The Medical Director provides leadership and management for the program to ensure the efficient, effective and quality delivery of inpatient and/or outpatient services; provides leadership that ensures effective functioning of the program in matters of strategic planning, program development and clinical quality; works collaboratively in a matrix model to ensure the effective development and implementation of services to the communities served; positions the program to be responsive within a highly managed care health care environment; aligns program goals with hospital or entity and regional goals.

Key Relationships:
1. The Hospital Chief Executive, Chief Nursing Executive, Program Administrator or CEO or CMO of service area or entity
(also reports to one of these people).
2. Other physicians who are part of or interact with the Program.
3. Customers and constituents whom the Medical Directors works with to promote the success of the Program.

QUALIFICATIONS:

The qualifications for the position are the minimum requirements needed to be successful in the position. The level of experience and expertise for the job is determined by the current amount of expertise in the unit/department. If training or experience is not required but would be desirable, it is listed as preferred however, persons without preferred background will be considered in the hiring process.

Education, Training & Experience (includes licenses or certifications):

1. MD/DO degree from an accredited program required
2. Board certified in program specialty required.
3. Licensed to practice in the State of Oregon.
4. Minimum of five years of practice experience
5. Management experience preferred.
6. Meets all credentialing criteria required by participating physicians.

CMFC & BNC ONLY- In compliance with company policy and state regulations, a Department of Human Services (DHS) background check is required for this position.

Knowledge, Skills & Abilities:

1. Ability to set a strategic vision with measurable outcomes that promote program development and success.
2. Ability to build a collaborative and supportive culture for medical program.
3. Strong management and proven leadership skills required.
4. Ability to work collaboratively across multiple business units, at all levels of management and within Providence Health and Services System.
5. Ability to organize and facilitate meetings and outcomes.
6. Willingly accepts direction in achievement of organization's objectives.
7. Organizational skills, including working collaboratively with other operational units within the Providence Health and Services System.
8. Understanding of and commitment to stewardship in both medical management and business reality.
9. Strong business acumen relating to program operations, finance and decision making.

Special Equipment Utilized:

Computer, Microsoft office products and equipment necessary to the program success.

STANDARDS OF PERFORMANCE:

Each of these are considered an essential function:

1. Actively supports and incorporates the mission and core values into daily activities. Treats all others with respect and demonstrates excellence, justice and compassion in daily work and relationships with others.

2. Maintains confidentiality of all information related to patients, medical staff, employees, and as appropriate, other information.

3. Demonstrates service excellence and positive interpersonal relations in dealing with others, including patients/families/members, employees, managers, medical staff, volunteers and community members, so that productivity and positive relations are maximized.

4. Consistently demonstrates and incorporates principles of safety and infection control into daily activities as outlined in Environment of Care, Infection Control, and Exposure Control manuals and department safety policies/procedures. Consistently uses personal protective equipment as required and takes appropriate precautions whenever there is potential for contact with blood, body fluids, chemicals and/or other hazardous materials. Maintains knowledge of work-appropriate aspects of environment of care programs, complies with policies and reports unsafe conditions. Successfully completes Environment of Care

Healthstream modules in the required timeframes and participates in fire drills and emergency exercises.

5. Develops individual objectives consistent with the Providence Health System's Oregon Management System. Measures and reports on individual objectives quarterly.

6. Integrates Quality Improvement principles in work life:

    a. Displays consistent commitment to customer service.

    b. Exhibits quality focus and active involvement in improvement of work processes.

    c. Employs learned methods for achieving improved outcomes.

    d. Demonstrates appreciation of team strength in meeting customers needs and displays personal behavior that has a positive impact for the team.

    e. Exhibits achievement and learning orientation to work and organizational life by maintaining a broad outlook, demonstrating personal responsibility for keeping up with current information, expanding knowledge and skill, and ensuring contribution to organizational success.

    f. Displays ability to work in an ever-changing environment and participate constructively in change processes.

7. Completes annual mandatory education review and competency program.

Age Related: No

Principal Duties And Functions (* indicates essential functions):

Patient Care: The Medical Director will provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.

Medical Knowledge: The Medical Director will demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and the application of this knowledge to patient care and in the program for which they are responsible.

Practice based Learning and Improvement: The Medical Director will demonstrate the ability to use scientific evidence and methods to investigate, evaluate, standardize and improve their patient care practices.

Interpersonal and Communication Skills; the Medical Director will demonstrate interpersonal and communication skills that enable him/her to establish and maintain professional relationships with patients, families, visitors, members of the community and other members of the health care team including hospital management and employees.

Interpersonal and Communication Skills: The Medical Director will demonstrate interpersonal and communication skills that enable him/her to establish and maintain professional relationships with patients, families, visitors, members of the community and other members of the health care team including hospital management and employees

Professionalism: The Medical Director will demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward patients, their profession, and society.

Leadership: The Medical Director will participate in and sets strategic planning for the program; Lead providers to understand and meet quality goals, patient satisfaction goals and financial goals in collaboration and partnership leadership; serve as the principal spokesperson and advocate for the program relating to quality assurance, utilization review, and outcomes management; leads efforts to support the continuous improvement of program including, quality outcomes, evidence based standardization, operational workflows, fiscal performance, and patient satisfaction.

Behaves in a manner that is consistent with the Providence Health & Services Mission and Core Values and the Roman Catholic moral tradition as articulated in such documents as The Ethical and Religious Directives for Catholic Health Care Services.

Major Challenges:

Setting measurable program outcomes that coordinate with leadership and regional objectives
Meeting the outcomes of the program while serving the community in a time of rapid change in the organization of health care delivery.
Developing rapport with fellow physicians and the understanding of the dynamics of effective services within the managed care environment
Creating opportunities for comparison/development/collaborative systems.

IN AN 8 HOUR WORKDAY, THIS JOB REQUIRES:

R = Rarely (less than 2 hours per day) **O** = Occasionally (2 - 2.5 hours per day)

F = Frequently (2.5 - 5.5 hours per day) **C** = Continually (5.5 - 8 hours per day)

PHYSICAL REQUIREMENTS	R	O	F	C	N/A	COMMENTS
Sitting			◉			
Stationary Standing			◉			
Walking			◉			
Ability To Be Mobile			◉			
Crouching (bending at the knees)	◉					
Kneeling/Crawling	◉					
Stooping (bending at the waist)	◉					
Twisting (knees / waist / neck)	◉					
Turning/Pivoting	◉					
Climbing	◉					
Balancing		◉				

Reaching Overhead		◉				
Reaching Extension		◉				
Grasping		◉				
Pinching		◉				
Pushing/Pulling	**R**	**O**	**F**	**C**	**N/A**	**COMMENTS**
Typical Weight (enter weight in comments field)		◉				25 lbs
Maximum Weight (enter weight in comments field)		◉				25 lbs
Lifting/Carrying	**R**	**O**	**F**	**C**	**N/A**	**COMMENTS**
Typical Weight (enter weight in comments field)		◉				25 lbs
Maximum Weight (enter weight in comments field)		◉				50 lbs
Other Physical Demands	**R**	**O**	**F**	**C**	**N/A**	**COMMENTS**
Keyboard Typing			◉			
SENSORY REQUIREMENTS	**R**	**O**	**F**	**C**	**N/A**	**COMMENTS**
Talking In Person			◉			
Talking On Telephone			◉			
Hearing In Person			◉			
Hearing On Telephone			◉			
Vision For Close-Up Work			◉			
Other Sensory Requirements					◉	
ENVIRONMENTAL SETTING	**R**	**O**	**F**	**C**	**N/A**	**COMMENTS**
Safety Requirements (i.e. clothing, safety equipment required, activities performed)		◉				Pending the program, may require safety clothing.
Exposures (i.e. fumes, chemicals, vibrations, humidity, cold, heat, dust, noise, blood & body fluids)		◉				
Operation Of Equipment, Tools, Vehicles		◉				
Required Hygiene Standards (i.e. food handling, clean, contaminated and sterile equipment, etc.)			◉			

Other Environmental Requirements						

Addendum:

The above is intended to describe the general content of, and requirements for, the performance of this job. It is not to be construed as an exhaustive statement of duties, responsibilities or requirements and does not limit the assignment of additional duties at the discretion of the supervisor.

Exhibit 9
Single Line Drawings

Providence Home Health

Single Line Drawings

Hospice:

Offices, Supply Room, and Cubicles

Home Health:

Storage Area, Supplies, and Cubicles

11 Unoccupied Cubicles*

41 Unoccupied Workstations*

***These unoccupied cubicles and workstations are available for any net new staff hired to serve in Clark County**

Address:
4400 NE Halsey Street, Building 1, Ste 160, Portland, OR 97213

Exhibit 10
Providence Home Health Facility Titles

Title: 4400 NE Halsey Street, Building 1, Ste. 160, Portland, OR 97213.

PARTITION PLAT NO. 2008-108

A REPLAT OF LOTS 13 - 18, BLOCK 2, BELGRADE AND OTHER LAND
LOCATED IN THE NW 1/4 OF SECTION 31, T. 1 N., R. 2 E., W.M.
CITY OF PORTLAND, MULTNOMAH COUNTY, OREGON.
DATE: JULY 14, 2008

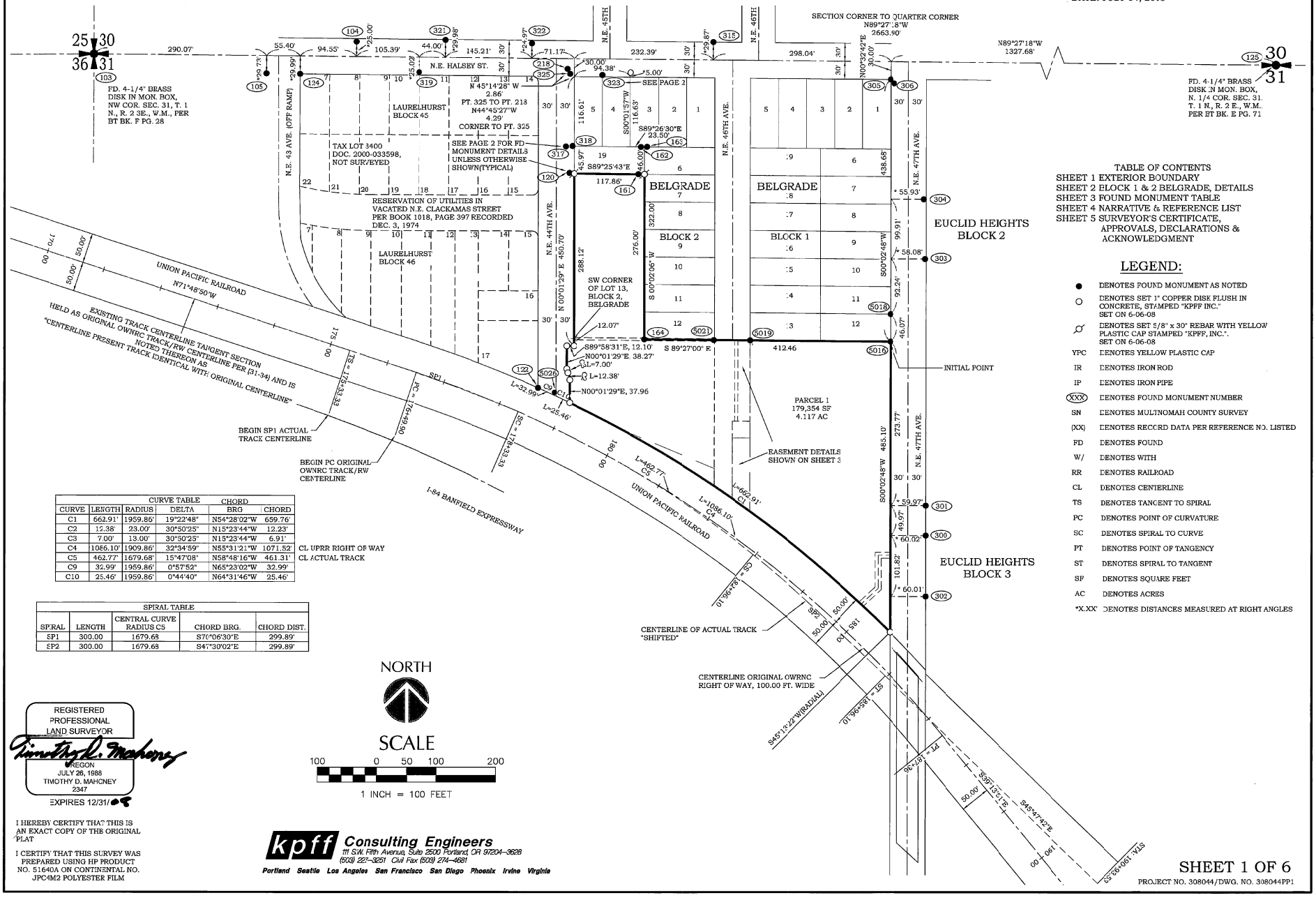


TABLE OF CONTENTS

LEGEND:

●	DENOTES FOUND MONUMENT AS NOTED
○	DENOTES SET 1" COPPER DISK FLUSH IN CONCRETE, STAMPED "KPFF INC." SET ON 6-06-08
⌀	DENOTES SET 5/8" x 30" REBAR WITH YELLOW PLASTIC CAP STAMPED "KPFF, INC.". SET ON 6-06-08
YPC	DENOTES YELLOW PLASTIC CAP
IR	DENOTES IRON ROD
IP	DENOTES IRON PIPE
(XXX)	DENOTES FOUND MONUMENT NUMBER
SN	DENOTES MULTNOMAH COUNTY SURVEY
(XX)	DENOTES RECORD DATA PER REFERENCE NO. LISTED
FD	DENOTES FOUND
W/	DENOTES WITH
RR	DENOTES RAILROAD
CL	DENOTES CENTERLINE
TS	DENOTES TANGENT TO SPIRAL
PC	DENOTES POINT OF CURVATURE
SC	DENOTES SPIRAL TO CURVE
PT	DENOTES POINT OF TANGENCY
ST	DENOTES SPIRAL TO TANGENT
SF	DENOTES SQUARE FEET
AC	DENOTES ACRES
*X.XX'	DENOTES DISTANCES MEASURED AT RIGHT ANGLES

CURVE TABLE				CHORD	
CURVE	LENGTH	RADIUS	DELTA	BRG	CHORD
C1	662.91'	1959.86'	19°22'48"	N54°28'02"W	659.76'
C2	12.38'	23.00'	30°50'25"	N15°23'44"W	12.23'
C3	7.00'	13.00'	30°50'25"	N15°23'44"W	6.91'
C4	1086.10'	1909.86'	32°34'59"	N55°31'21"W	1071.52'
C5	462.77'	1679.68'	15°47'08"	N58°48'16"W	461.31'
C9	32.99'	1959.86'	0°57'52"	N65°23'02"W	32.99'
C10	25.46'	1959.86'	0°44'40"	N64°31'46"W	25.46'

CL UPRR RIGHT OF WAY
CL ACTUAL TRACK

SPIRAL TABLE				
SPIRAL	LENGTH	CENTRAL CURVE RADIUS CS	CHORD BRG.	CHORD DIST.
SP1	300.00	1679.68	S7°06'30"E	299.89'
SP2	300.00	1679.68	S4°30'02"E	299.89'

REGISTERED PROFESSIONAL LAND SURVEYOR
OREGON
JULY 26, 1988
TIMOTHY D. MAHONEY
2347
EXPIRES 12/31/

I HEREBY CERTIFY THAT THIS IS AN EXACT COPY OF THE ORIGINAL PLAT

I CERTIFY THAT THIS SURVEY WAS PREPARED USING HP PRODUCT NO. 51640A ON CONTINENTAL NO. JPC4M2 POLYESTER FILM

kpff Consulting Engineers
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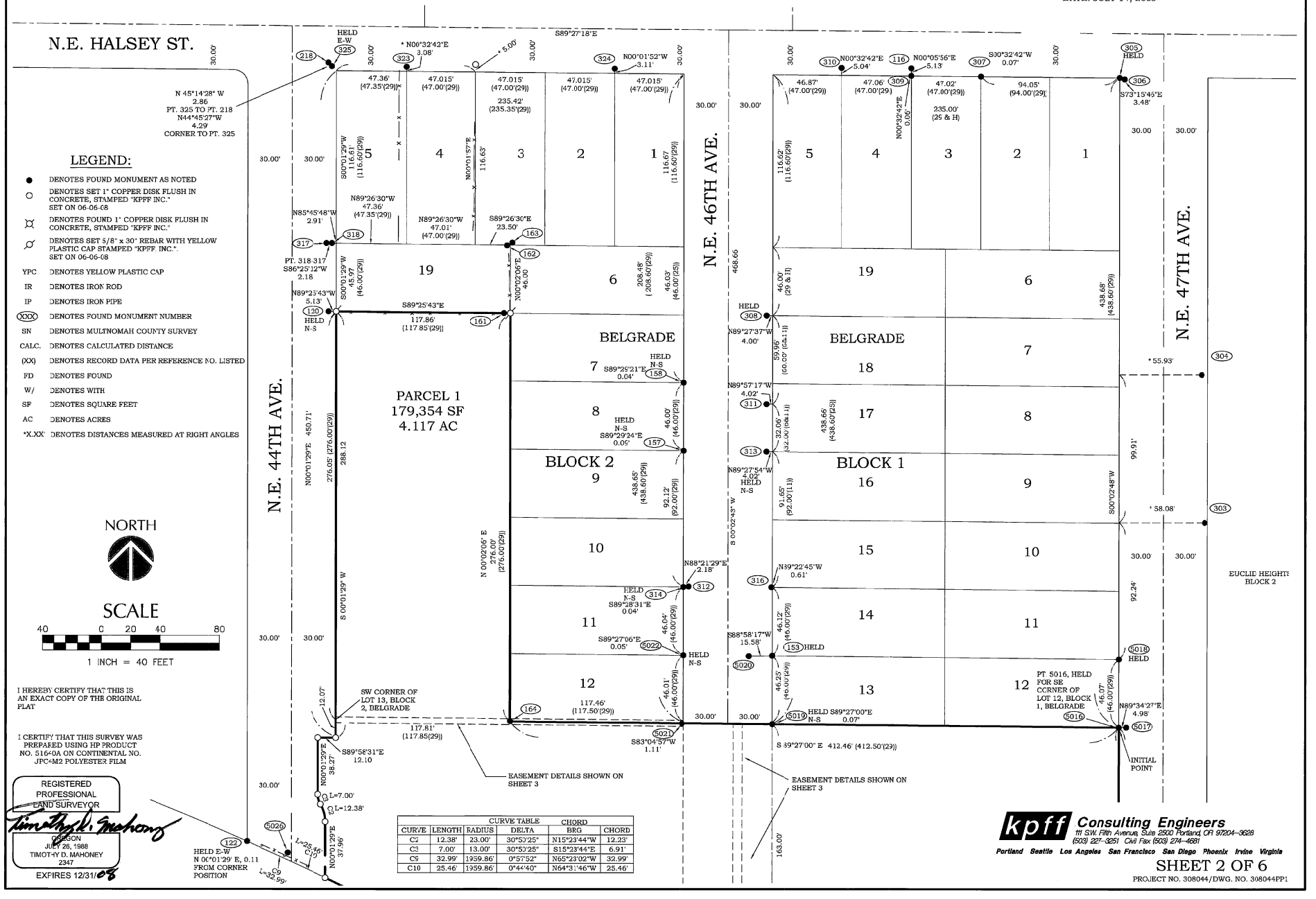
Portland Seattle Los Angeles San Francisco San Diego Phoenix Irvine Virginia

PARTITION PLAT NO. 2008-108

A REPLAT OF LOTS 13 - 18, BLOCK 2, BELGRADE AND OTHER LAND
LOCATED IN THE NW 1/4 OF SECTION 31, T. 1 N., R. 2 E., W.M.
CITY OF PORTLAND, MULTNOMAH COUNTY, OREGON.
DATE: JULY 14, 2008



LEGEND:

●	DENOTES FOUND MONUMENT AS NOTED
○	DENOTES SET 1" COPPER DISK FLUSH IN CONCRETE, STAMPED "KPFF INC." SET ON 06-06-08
⊠	DENOTES FOUND 1" COPPER DISK FLUSH IN CONCRETE, STAMPED "KPFF INC."
⊗	DENOTES SET 5/8" x 30" REBAR WITH YELLOW PLASTIC CAP STAMPED "KPFF INC.". SET ON 06-06-08
YPC	DENOTES YELLOW PLASTIC CAP
IR	DENOTES IRON ROD
IP	DENOTES IRON PIPE
(XXX)	DENOTES FOUND MONUMENT NUMBER
SN	DENOTES MULTNOMAH COUNTY SURVEY
CALC.	DENOTES CALCULATED DISTANCE
(XX)	DENOTES RECORD DATA PER REFERENCE NO. LISTED
FD	DENOTES FOUND
W/	DENOTES WITH
SF	DENOTES SQUARE FEET
AC	DENOTES ACRES
*X.XX'	DENOTES DISTANCES MEASURED AT RIGHT ANGLES

NORTH

SCALE

40 0 20 40 80

1 INCH = 40 FEET

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REGISTERED PROFESSIONAL LAND SURVEYOR

OREGON
JULY 26, 1988
TIMOTHY D. MAHONEY
2347

EXPIRES 12/31/08

CURVE TABLE					
CURVE	LENGTH	RADIUS	DELTA	CHORD BRG	CHORD
C2	12.38'	23.00'	30°50'25"	N15°23'44"W	12.23'
C3	7.00'	13.00'	30°50'25"	S15°23'44"E	6.91'
C9	32.99'	1959.86'	0°57'52"	N65°23'02"W	32.99'
C10	25.46'	1959.86'	0°44'40"	N64°31'46"W	25.46'

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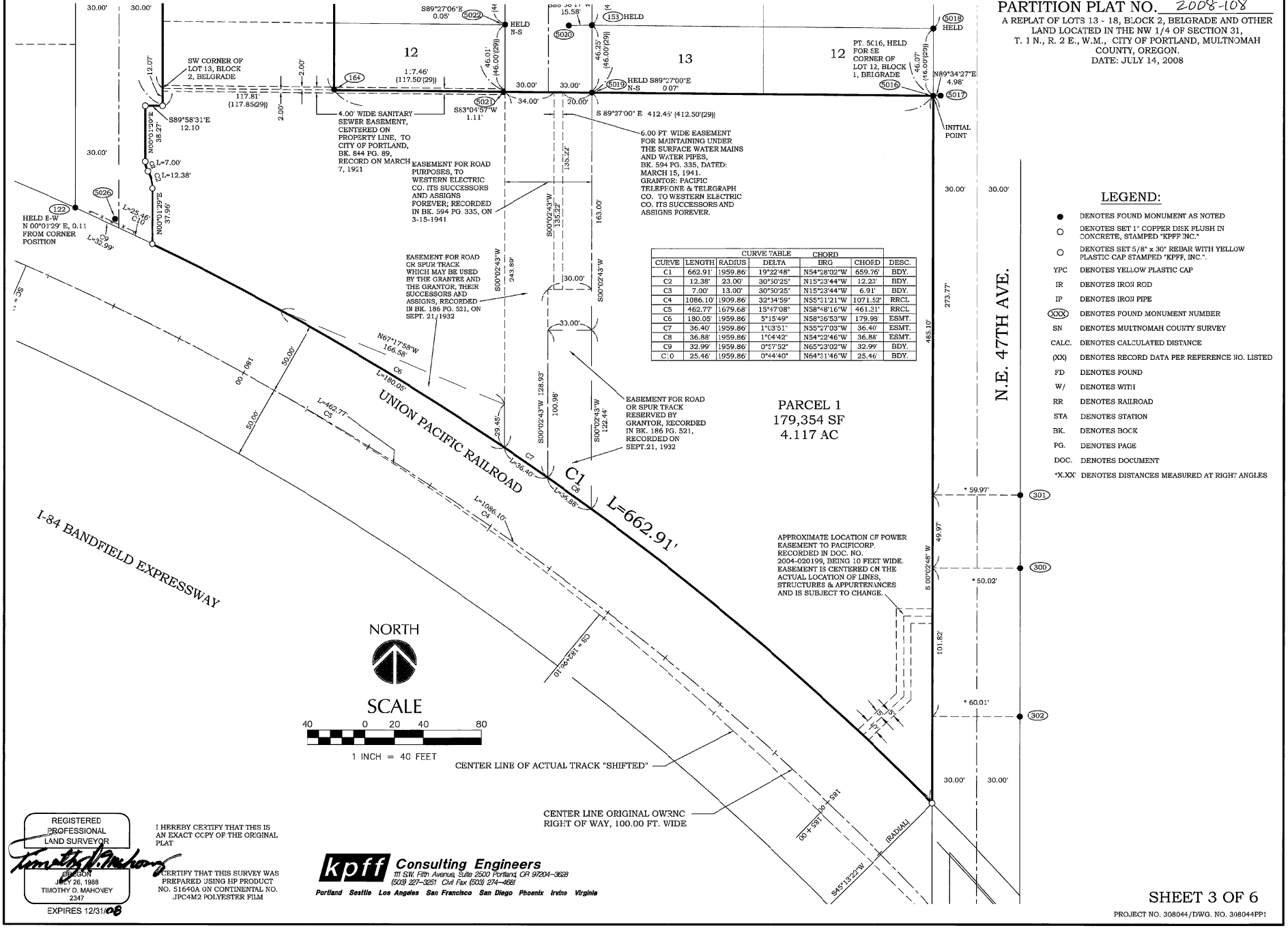
SHEET 2 OF 6

PROJECT NO. 308044/DWG. NO. 308044PP1

PARTITION PLAT NO. 2008-108

A REPLAT OF LOTS 13 - 18, BLOCK 2, BELGRADE AND OTHER LAND LOCATED IN THE NW 1/4 OF SECTION 31, T. 1 N., R. 2 E., W.M., CITY OF PORTLAND, MULTNOMAH COUNTY, OREGON.
DATE: JULY 14, 2008



CURVE TABLE				CHORD		
CURVE	LENGTH	RADIUS	DELTA	BRG	CHORD	DESC.
C1	662.91'	1959.86'	19°22'48"	N54°28'02"W	659.76'	BDY.
C2	12.38'	23.00'	30°50'25"	N15°23'44"W	12.23'	BDY.
C3	7.00'	13.00'	30°50'25"	N15°23'44"W	6.91'	BDY.
C4	1086.10'	1909.86'	32°34'59"	N55°31'21"W	1071.52'	RRCL
C5	462.77'	1679.68'	15°47'08"	N58°48'16"W	461.31'	RRCL
C6	180.05'	1959.86'	5°15'49"	N58°36'53"W	179.99	ESMT.
C7	36.40'	1959.86'	1°03'51"	N55°27'03"W	36.40'	ESMT.
C8	36.88'	1959.86'	1°04'42"	N54°22'46"W	36.88'	ESMT.
C9	32.99'	1959.86'	0°57'52"	N65°23'02"W	32.99'	BDY.
C10	25.46'	1959.86'	0°44'40"	N64°31'46"W	25.46'	BDY.

LEGEND:

●	DENOTES FOUND MONUMENT AS NOTED
○	DENOTES SET 1" COPPER DISK FLUSH IN CONCRETE, STAMPED "KPFF INC."
○	DENOTES SET 5/8" x 30" REBAR WITH YELLOW PLASTIC CAP STAMPED "KPFF, INC.".
YPC	DENOTES YELLOW PLASTIC CAP
IR	DENOTES IRON ROD
IP	DENOTES IRON PIPE
XXX	DENOTES FOUND MONUMENT NUMBER
SN	DENOTES MULTNOMAH COUNTY SURVEY
CALC.	DENOTES CALCULATED DISTANCE
(XX)	DENOTES RECORD DATA PER REFERENCE NO. LISTED
FD	DENOTES FOUND
W/	DENOTES WITH
RR	DENOTES RAILROAD
STA	DENOTES STATION
BK.	DENOTES BOOK
PG.	DENOTES PAGE
DOC.	DENOTES DOCUMENT
*X.XX'	DENOTES DISTANCES MEASURED AT RIGHT ANGLES

REGISTERED PROFESSIONAL LAND SURVEYOR
OREGON
JULY 26, 1988
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2347
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SHEET 3 OF 6

PROJECT NO. 308044/DWG. NO. 308044PP1

PARTITION PLAT NO. 2008-108

A REPLAT OF LOTS 13 - 18, BLOCK 2, BELGRADE AND OTHER LAND
LOCATED IN THE NW 1/4 OF SECTION 31, T. 1 N., R 2 E., W.M.
CITY OF PORTLAND, MULTNOMAH COUNTY, OREGON.
DATE: JULY 14, 2008

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FOUND MONUMENT TABLE

PT.NO.	BEARING	DISTANCE	DESCRIPTION
103	HELD	HELD	FD 4-1/4" BD STAMPED "T.1N. R.1E., T.1N. R.2E., 25, 30, 31, 36, 1967" W/ PUNCH MARK IN MONUMENT BOX
104			FD BS IN SIDEWALK, NO WASHER [FD (25)]
105			FD 5/8" IR W/1-1/2" ALUM. CAP STAMPED "OTAK INC.", FLUSH [SET (20)]
116	N00°05'56"E	5.13'	FD BS [FD (5 & 11 & 17)]
120	N89°25'43"E	5.13'	FD BS COP [SET (17)]HELD N-S
122	N00°01'29"E	0.11'	FD 1" IRON PIPE, HELD EAST-WEST [FD (3 & 7)] N 00°01'29" E, 0.11 FROM CORNER
123	N02°14'48"W	5.13'	FD BS W/ 3/4" BRASS WASHER STAMPED "OTAK" [SET (20)]
124	N64°06'45"W	0.01'	FD BS W/ 3/4" BRASS WASHER STAMPED "OTAK INC." [SET (20) FD (28)]
125	HELD	HELD	FD 4-1/4" BD STAMPED "T.1N. R.2E., 30, 31" W/PUNCH MARK, [FD (20) B.T. BK.G, PG.170]
153	HELD	HELD	FD 1/2" IRON PIPE, ORIGIN UNKNOWN, [FD (10 & 11)]
157	S89°29'24"E	0.09'	FD 1/2" IRON PIPE, UNKNOWN ORIGIN, HELD N-S
158	S89°29'21"E	0.04'	FD 1/2" IRON PIPE, UNKNOWN ORIGIN, HELD N-S
161	N76°58'00"W	0.51'	FD 5/8" IR, NO CAP, FLUSH, GOOD CONDITION [SET (14)]
162	S86°30'55"W	0.54'	FD 5/8" IR, NO CAP, DOWN 0.3', GOOD CONDITION [FD (14)]
163	N72°31'04"E	0.29'	FD 5/8" IR, NO CAP, [SET (14)]
164	N38°43'48"E	0.11'	FD 5/8" IR, NO CAP, [SET (11), FD (19)]
218	N45°04'40"W	7.10'	FD BS W/ 3/4" BRASS WASHER STAMPED "COP REPL" [SET (17)]
300			FD BS W/ 3/4" BRASS WASHER STAMPED "MARX A.F.S. ASSOCS" IN CONCRETE SIDEWALK [SET (23 FD (24)]
301			FD 5/8" IR W/YPC STAMPED "MARX & ASSOCS", DOWN 0.1', GOOD CONDITION [SET (23 FD (24)]
302			FD BS W/3/4" BRASS WASHER STAMPED "CENTERLINE CONCEPTS" [SET (24)]
303			FD TACK IN LEAD PLUG IN SIDEWALK, ORIGIN UNKNOWN, [FD (23)]
304			FD BS IN LEAD PLUG IN CONCRETE SIDEWALK, GOOD CONDITION, ORIGIN UNKNOWN
305	N00°02'48"E	0.02'	FD 1/2" IR, NO CAP, VERTICAL, UP 0.1', GOOD CONDITION, HELD E-W [SET (5) FD (22 & 23)]
306	S73°15'46"E	3.48'	FD BS W/3/4" BRASS WASHER STAMPED "OTAK INC." IN CONCRETE SIDEWALK [SET (20)]
307	N00°32'42"E	0.07'	FD 1/2" IR, NO CAP, UP 0.2', GOOD CONDITION [SET (5)]
308	N89°27'37"W	4.00'	FD TACK IN LEAD PLUG IN CONCRETE SIDEWALK, HELD AS 4.00' OFFSET [SET (4) FD (6 & 10 & 11)]
309	N00°32'42"E	0.06'	FD 1/2" IRON PIPE, UP 0.4', GOOD CONDITION [FD (8)]
310	N00°32'42"E	5.04'	FD BS IN LEAD PLUG IN CONCRETE SIDEWALK, NO WASHER, GOOD CONDITION [FD (5 & 8)]
311	N89°57'17"W	4.02'	FD BS IN LEAD PLUG IN CONCRETE SIDEWALK, NO WASHER, GOOD CONDITION [SET (4) FD (6, 10 & 11)]
312	N88°21'29"E	2.18'	FD BS IN LEAD PLUG IN CONCRETE SIDEWALK, NO WASHER, GOOD CONDITION, ORIGIN UNKNOWN, [FD (10)]
313	N89°27'54"W	4.02'	FD BS IN LEAD PLUG IN CONCRETE SIDEWALK, NO WASHER GOOD CONDITION, [SET (5) FD (10 & 11)], HELD N-S
314	S89°28'31"E	0.04'	FD 5/8" IR, NO CAP, DOWN 0.1', LEANS SLIGHTLY NORTHWEST, [SET (10)], HELD N-S
315			FD 1/2" IRON PIPE, UP 0.1', GOOD CONDITION, ORIGIN UNKNOWN, [FD (13 & 17)]
316	N89°22'45"W	0.61'	FD 1/2" IRON PIPE, FLUSH, GOOD CONDITION, ORIGIN UNKNOWN, HELD N-S
317	N89°06'44"W	5.07'	FD BS W/ 3/4" BRASS WASHER STAMPED "COP REPL" IN CONCRETE SIDEWALK, GOOD CONDITION [SET (17)]
318	N85°45'48"W	2.91'	FD BS W/ 3/4" BRASS WASHER STAMPED "COP REPL" IN CONCRETE SIDEWALK, GOOD CONDITION [SET (17)]
319			FD PK NAIL W/OLD SHINER IN CONCRETE SIDEWALK, ORIGIN UNKNOWN
321			FD 5/8' IR W/YPC STAMPED "BUCKLES PLS #2231", FLUSH, GOOD CONDITION [SET (25) FD (28)]
322			FD BS W/PUNCH MARK IN CONCRETE SIDEWALK, NO WASHER FD (14 & 25 & 28)]
323	N00°24'50"E	3.08'	FD BS IN LEAD PLUG IN CONCRETE SIDEWALK [SET (17)]
324	N00°01'52"W	3.11'	FD TACK IN LEAD PLUG, IN CONCRETE SIDEWALK, ORIGIN UNKNOWN, [FD (14)]
325	N44°58'04"W	4.24'	FD BS W/3/4" BRASS WASHER STAMPED "COP REPL" IN CONCRETE SIDEWALK, HELD E-W [SET (17)]
5016	HELD	HELD	FD 2-1/2" BRASS DISK IN CONCRETE, IN SQUARE MONUMENT BOX, 0.8' BELOW LID [FD (18 & 19 & 22)]
5017	N89°34'27"E	4.98'	FD 3/8' BRASS SCREW IN CONCRETE SIDEWALK, NO WASHER, [FD (18 & 22 & 23)]
5018	HELD	HELD	FD 5/8' IR W/YPC STAMPED "COMPASS CORP.", DOWN 0.1' [SET (22)]
5019	S89°27'00"E	0.07'	FD 1/2' IRON PIPE IN CONCRETE WALL, HELD N-S, ORIGIN UNKNOWN
5020	S88°58'17"W	15.58'	FD 1/2' IRON PIPE AT BACK OF CURB, ORIGIN UNKNOWN
5021	S83°04'57"W	1.11'	FD 1/4' IRON PIPE IN CONCRETE WALL WITH FENCE, [SET (11)]
5022	S89°27'06"E	0.05'	FD 1/2' IR, NO CAP, DOWN 0.1' [SET (11), FD (10 & 19)], HELD N-S
5026	N21°37'31"W	6.57'	FD BS W/3/4" BRASS WASHER STAMPED "OTAK INC." IN SIDEWALK, [SET (20)]

LEGEND:

YPC	DENOTES YELLOW PLASTIC CAP
IR	DENOTES IRON ROD
IP	DENOTES IRON PIPE
BD	DENOTES BRASS DISK
(XX)	DENOTES RECORD DATA PER REFERENCE NO. LISTED
FD	DENOTES FOUND
W/	DENOTES WITH
BS	DENOTES BRASS SCREW
ALUM	DENOTES ALUMINUM
COP	DENOTES CITY OF PORTLAND

REGISTERED
PROFESSIONAL
LAND SURVEYOR
OREGON
JULY 26, 1988
TIMOTHY D. MAHONEY
2347
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REFERENCE LIST:

	SN NUMBER
1	5130
2	10354
3	13992
4	21519
5	22369
6	25954
7	27332
8	31937
9	32918
10	36358
11	36391
12	37270
13	37797
14	38538
15	40593
16	44891
17	45183
18	47609
19	48781
20	49932
21	50229
22	52495
23	52496
24	53808
25	56495
26	57417
27	59122
28	61246

PLATS

29 BELGARDE BK. 517 PG. 11
30 EUCLID HEIGHTS BK. 517 PG. 9
31 LAURELHURST BK. 515 PG. 97

UNION PACIFIC RAILROAD MAPS (OREGON -WASHINGTON RAILROAD & NAVIGATION CO. MAPS)

32 CE. 33239-3 S3 OF 6, V-2
33 CE 33239-4, S4 OF 6, V-2 PORTLAND TO GRAHAM
34 CE 33199-4, S4 OF 6, V-2, STATION MAP PORTLAND, OR.
35 CE 81309-3, S3 OF 4, V-1

CONDITIONS AND RESTRICTIONS

36 BK. 1644, PG. 103, INST. NO. 005861, 2-16-1954
37 BK. 1754, PG. 445, INST. NO. 046084, 9-19-1955
38 BK. 1303, PG. 523, INST. NO. 083175, 10-19-1978
39 BK. 2086, PG. 1988, INST. NO. 017785, 3-14-1988
40 INST. NO. 2003-131209, 6-09-2003

DEEDS AND LEASE AGREEMENTS

40 LEASE OF PROPERTY AGREEMENT BETWEEN UPRR AND PROVIDENCE, DATED DEC. 10, 2000. REFERENCE UPRR FILE FOLDER NO. 000829-49.
41 BK. 1233, PG. 1353, 1-10-1978, CURRENT VESTING DEED TAX LOTS 2800 AND 2900
42 BK. 844, PG. 89, INST. NO. 237924, 3-07-1921, EASEMENT
43 BK. 186, PG. 521, 9-21-1932, EASEMENT FOR SPUR TRACK
44 BK. 594, PG. 335, 3-15-1941, EASEMENT FOR ROAD AND UTILITIES
45 BK. 1990, PG. 2285, INST. NO. 90022499, 3-19-1990, EASEMENT
46 BK. 2188, PG. 1979, 3-27-1989, DEED FOR STREET PURPOSES
47 BK. 47, PG. 264, 6-30-1881, DEED LADD TO OWRNC RAILROAD
48 2000-055026, 4-20-2000, DEED

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NARRATIVE

THE PURPOSE OF THIS SURVEY IS TO COMPLETE A LOT CONSOLIDATION PLAT OF THAT TRACT OF LAND DESCRIBED IN PARCELS 'A' AND 'B' THAT CERTAIN DEED RECORDED IN BK. 1233, PG. 1353, ON 1/10/1978, DEED RECODRD OF MULTNOMAH COUNTY, OREGON, EXCEPT THE PORTION WITHIN NE 44 AVENUE.

THE EXTERIOR BOUNDARY WAS DETERMINED AS FOLLOWS:

SOUTH LINE (RAILROAD RIGHT OF WAY LINE)
THE RAILROAD WAS FORMERLY A LINE OWNED AND OPERATED BY THE OREGON WASHINGTON RAILROAD & NAVIGATION COMPANY (OWRNC) AND IS NOW OWNED AND OPERATED BY THE UNION PACIFIC RAILROAD (UPRR). THE RIGHT OF WAY IN THIS SECTION IS 100.00 FEET WIDE CENTERED ON THE ORIGINAL OWRNC MAIN LINE TRACK CENTERLINE, AS DENOTED ON OWRNC STATION MAPS AND NOTED HEREON AS UPRR MAPS (31-34). THE EXISTING (ORIGINAL OWRNC) TRACK WAS RE-ALIGNED (SHIFTED) EAST OF THE TANGENT SECTION BEGINNING AT STATION 175+33.33. SAID UPRR MAPS (31-34) NOTE THIS NEW ALIGNMENT AS "TRACK SHIFTING". NEW CURVE DATA IS NOTED THEREON FOR THE CURVE SECTION (TAPER CURVES ON EACH SIDE OF AND THE CENTRAL CURVE). THE TANGENT SECTION WEST OF STATION 175+33.33 IS NOTED ON SAID UPRR MAPS (31-34) AS "CENTER LINE PRESENT TRACK IDENTICAL WITH ORIGINAL CENTER LINE". THE EXISTING TRACK CENTERLINE WAS LOCATED FROM STATION 163+64.42 TO STATION 190+93.53. A BEST FIT LINE WAS CALCULATED AND HELD FOR THE TANGENT SECTION BETWEEN STA. 164+56.8 TO STA. 176+49.9 PC. RAILROAD STATIONING WAS DETERMINED BY HOLDING THE SIGNAL POST OPPOSITE STATION 164+56.8, PER (31-34). HELD THE TANGENT DISTANCE OF 1193.1 FEET PER (31-34) TO DETERMINE THE PC AT STA. 176+49.9. HELD THE CENTRAL CURVE DATA (RADIUS, DELTA AND LENGTH) PER (31-34) TO DETERMINE THE CURVE SECTION. THERE IS NO SPIRAL OR TAPER CURVES, AS SAID UPRR MAPS (31-34) SHOW ONLY A SIMPLE CURVE BETWEEN THE TANGENTS ON THE ORIGINAL OWRNC CENTER LINE. IN THE CURVE SECTION THE ACTUAL TRACK ALIGNMENT DID NOT FIT THE SHIFTED/NEW ALIGNMENT TRACK DATA AS NOTED ON SAID UPRR MAPS (31-34) VERY WELL. THE SURVEY FIELD CREW FOUND AND NOTED UPRR SURVEYORS MARKINGS FOR THE MAINTENANCE CREWS ON THE TRACK TIES, NOTING THEIR TRACK ALIGNMENT DATA (D= 03° 24' 40", 2 EQUAL SPRIALS, LENGTH = 300'). HELD SAID FOUND FIELD MARKING (DEGREE OF CURVE AND SPRIAL LENGTH) TO LAY OUT THE ACTUAL TRACK CENTER LINE POSITION AS SHOWN HEREON. A BEST FIT LINE WAS CALCULATED AND HELD FOR THE TANGENT SECTION BETWEEN STA. 187+36.00 PT TO STA. 190+93.53 POT. THE UPRR RIGHT OF WAY LINE CHANGES ON THE NORTHERLY EDGE EAST OF N.E. 47TH AVENUE, AND WAS NOT DETERMINED BY THIS SURVEY.

WEST LINE (NE 47TH AVENUE)
HELD FOUND MONUMENTS AT POINT No. 305 AND 5016 FOR THE WEST RIGHT OF WAY LINE PER (5, 18, 19, 22 & 23). HELD RECORD RIGHT OF WAY WIDTH OF 60.00 FEET PER (29 & 26). THIS SOLUTION FITS THE FOUND MONUMENTS AT POINT NO. 'S 300, 301, 302.

NE 44TH AVENUE
HELD FOUND MONUMENTS AT POINT NO. 122 AND 325 PER (3, 2, 7, 13, 14, AND 17). HELD RECORD RIGHT OF WAY WIDTH OF 60.00 FEET PER (29 & 27). THE EAST RIGHT OF WAY LINE SOUTH OF THE PLAT OF BELGRADE WAS DETERMINED BY HOLDING THE DEED CALL FOR THE STREET RIGHT OF WAY CONVEYED FROM SISTERS OF PROVIDENCE TO CITY OF PORTLAND, PER DEED BK, 2188, PG. 1979, RECORDED MARCH 27, 1989.

NE HALSEY STREET
HELD FOUND MONUMENTS AT POINT NO. 103 AND 125 PER (20). HELD RECORD RIGHT OF WAY WIDTH OF 60.00 FEET PER (20, 29, & 27).

NE 46TH AVENUE
HELD FOUND MONUMENT AT POINT NO. 153. HELD FOUND MONUMENT AT POINT NO. 308 AS A 4.00 FOOT OFFSET PER (11). HELD RECORD RIGHT OF WAY WIDTH OF 60.00 FEET PER (29). THIS SOLUTION FITS WITH FOUND MONUMENTS AT POINT NO'S. 158, 314, AND 5022.

PLAT OF BELGRADE
SOUTH LINE BELGRADE WAS DETERMINED BY HOLDING THE FOUND MONUMENTS AT POINT NO. 5016 PER (18, 19, & 22) AND POINT NO. 5019, HELD AS AN ORIGINAL PLAT MONUMENT PER (26). THE SOUTH RIGHT OF WAY LINE OF NE HALSEY WAS HELD AS THE NORTH LINE OF BELGRADE. THE INTERIOR LOT LINES, WERE DETERMINED BY PRO-RATING RECORD PLAT DISTANCES BETWEEN THE FOUND AND HELD MONUMENTS AS NOTED IN THE MONUMENT TABLE ON SHEET 4, AND AS DETAILED ON SHEET 2.

(XX) DENOTES REFERENCE DATA.

BASIS OF BEARINGS IS BASED ON COMPASS READING . THE NORTH LINE OF THE NORTHWEST ONE QUARTER OF SECTION 31, IS NORTH 89°27'18" WEST, HOLDING THE FOUND MONUMENTS AT POINTS 125 AND 103.

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kpff Consulting Engineers
111 S.W. Fifth Avenue, Suite 2500 Portland, OR 97204-3628
(503) 227-3251 Civil Fax (503) 274-4681
Portland Seattle Los Angeles San Francisco San Diego Phoenix Irvine Virginia

SURVEYOR'S CERTIFICATE

I, TIMOTHY D. MAHONEY, HEREBY CERTIFY THAT I HAVE CORRECTLY SURVEYED AND MARKED WITH PROPER MONUMENTS THE LANDS REPRESENTED ON THIS PARTITION PLAT BEING DESCRIBED AS FOLLOWS:

A TRACT OF LAND LYING IN THE NORTHWEST QUARTER OF SECTION 31, TOWNSHIP 1 NORTH, RANGE 2 EAST OF THE WILLAMETTE MERIDIAN, CITY OF PORTLAND, MULTNOMAH COUNTY, OREGON. BEING A PORTION OF PARCELS 'A' AND 'B' OF THAT TRACT OF LAND DESCRIBED IN THAT CERTAIN DEED TO SISTERS OF PROVIDENCE IN OREGON, RECORDED IN BOOK 1233, PAGE 1353, ON 01-10-1978, DEED RECORDS OF SAID COUNTY, BEING MORE PARTICULARLY DESCRIBED AS FOLLOWS:

COMMENCING AT THE NORTH QUARTER CORNER OF SAID SECTION 31, MARKED BY A FOUND 4-1/4" BRASS DISK IN A MONUMENT BOX; THENCE COINCIDENT WITH THE NORTH LINE OF SAID SECTION 31 N89°27'18"W, 1327.68 FEET; THENCE S 00°32'42" W, 30.00 FEET TO THE NORTHEAST CORNER OF BLOCK 1, BELGRADE, RECORDED IN BOOK 514, PAGE 11, PLAT RECORDS OF SAID COUNTY; THENCE COINCIDENT WITH THE EAST LINE OF SAID BLOCK 1, ALSO BEING THE WEST RIGHT OF WAY LINE OF N.E. 47TH AVENUE S00°02'48"W, 438.68 FEET TO THE SOUTHEAST CORNER OF SAID BLOCK 1, MARKED BY A FOUND 2-1/2" BRASS DISK, ALSO BEING THE NORTHEAST CORNER OF SAID PARCEL 'B' AND THE **INITIAL POINT** OF THE HEREIN DESCRIBED TRACT; THENCE COINCIDENT WITH SAID WEST RIGHT OF WAY LINE SOUTH 00°02'48" WEST, 485.10 FEET TO THE SOUTHEAST CORNER OF SAID PARCEL 'B", BEING A POINT ON THE NORTHEASTERLY RIGHT OF WAY LINE OF THE UNION PACIFIC RAILROAD, SAID POINT ALSO BEING A POINT ON A 1959.86 FOOT RADIUS CURVE, THE RADIUS POINT OF WHICH BEARS SOUTH 45°13'22" WEST; THENCE NORTHWESTERLY COINCIDENT WITH SAID NORTHEASTERLY RIGHT OF WAY LINE AND SAID 1959.86 FOOT RADIUS CURVE TO THE LEFT, THROUGH A CENTRAL ANGLE OF 19°22'48", AN ARC DISTANCE OF 662.91 FEET, (THE LONG CHORD OF WHICH BEARS NORTH 54°28'02" WEST, 659.76 FEET) TO THE MOST SOUTHEAST CORNER OF THAT TRACT OF LAND DESCRIBED IN THAT CERTAIN DEED TO THE CITY OF PORTLAND FOR STREET PURPOSES, RECORDED IN BOOK 2188 PAGE 1979, ON MARCH 27, 1989; THENCE COINCIDENT WITH THE EAST LINES OF SAID CITY OF PORTLAND TRACT THE FOLLOWING SIX (6) COURSES AND DISTANCES: (1) NORTH 00°01'29" EAST, 37.96 FEET TO A POINT OF CURVATURE WITH A 23.00 FOOT RADIUS CURVE TO THE LEFT; (2) COINCIDENT WITH SAID 23.00 FOOT RADIUS CURVE LEFT, THROUGH A CENTRAL ANGLE OF 30°50'26", AN ARC DISTANCE OF 12.38 FEET (THE LONG CHORD OF WHICH BEARS NORTH 15°23'44" WEST, 12.23 FEET) TO A POINT OF REVERSE CURVATURE WITH A 13.00 FOOT RADIUS CURVE RIGHT; (3) COINCIDENT WITH SAID 13.00 FOOT RADIUS CURVE RIGHT, THROUGH A CENTRAL ANGLE OF 30°50'25", AN ARC DISTANCE OF 7.00 FEET (THE LONG CHORD OF WHICH BEARS NORTH 15°23'44" WEST, 6.91 FEET); (4) NORTH 00°01'29" EAST, 38.27 FEET; (5) SOUTH 89°58'31" EAST, 12.10 FEET; (6) NORTH 00°01'29" E 12.07 FEET TO THE NORTHEAST CORNER OF SAID CITY OF PORTLAND TRACT, ALSO BEING THE SOUTHWEST CORNER OF LOT 13 OF BLOCK 2, SAID PLAT OF BELGRADE, ALSO BEING A POINT ON THE EAST RIGHT OF WAY LINE OF NE 44TH AVENUE; THENCE COINCIDENT WITH SAID EAST RIGHT OF WAY LINE AND THE WEST LINE OF SAID BLOCK 2, NORTH 00°01'29" EAST, 288.12 FEET TO THE NORTHWEST CORNER OF LOT 18 OF SAID BLOCK 2; THENCE COINCIDENT WITH THE NORTH LINE OF SAID LOT 18, SOUTH 89°25'43" EAST, 117.86 FEET TO THE NORTHEAST CORNER THEREOF; THENCE COINCIDENT WITH THE EAST LINE OF SAID LOTS 13 THROUGH 18 OF SAID BLOCK 2, SOUTH 00°02'06" WEST, 276.00 FEET TO THE SOUTHEAST CORNER OF SAID LOT 13; THENCE COINCIDENT WITH THE SOUTH LINE OF SAID PLAT OF BELGRADE SOUTH 89°27'00" EAST, 412.46 FEET TO THE INITIAL POINT OF THE HEREIN DESCRIBED TRACT.

TOTAL AREA CONTAINING 4.117 ACRES MORE OR LESS.

Timothy D. Mahoney
TIMOTHY D. MAHONEY
REGISTERED PROFESSIONAL LAND SURVEYOR NO. 2347

REGISTERED
PROFESSIONAL
LAND SURVEYOR
Timothy D. Mahoney
OREGON
JULY 26, 1988
TIMOTHY D. MAHONEY
2347
EXPIRES 12/31/08

I HEREBY CERTIFY THAT THIS IS AN EXACT COPY OF THE ORIGINAL PLAT

I CERTIFY THAT THIS SURVEY WAS PREPARED USING HP PRODUCT NO. 51640A ON CONTINENTAL NO. JPC4M2 POLYESTER FILM

APPROVALS:

APPROVED THIS 4TH DAY OF August, 2008

BY: Mike M Stubbs (CXd)
CITY OF PORTLAND, PLANNING DIRECTOR'S DELEGATE

****

APPROVED THIS 30TH DAY OF JULY, 2008

BY: Cherrie M Eudaley
CITY OF PORTLAND, CITY ENGINEER'S DELEGATE

****

APPROVED THIS 12th DAY OF August, 2008
COUNTY SURVEYOR, MULTNOMAH COUNTY, OREGON

BY Robert A Hovden

****

ALL TAXES, FEES, ASSESSMENTS, OR OTHER CHARGES AS PROVIDED BY O.R.S. 92.095 HAVE BEEN PAID AS OF September 8th, 2008
DIRECTOR,
DIVISION OF ASSESSMENT & TAXATION,
MULTNOMAH COUNTY, OREGON

BY [signature]
DEPUTY

****

ACKNOWLEDGMENT

STATE OF OREGON)
) SS
COUNTY OF MULTNOMAH)

I DO HEREBY CERTIFY THAT THE ATTACHED PARTITION PLAT WAS RECEIVED FOR RECORD AND RECORDED Sep 8, 2008 AT 9:32 a.M IN

AS PARTITION PLAT NO. 2008-108.
COUNTY RECORDING OFFICE

BY VMcIntosh
DEPUTY

DOCUMENT NO. 2008-128211

DECLARATIONS

KNOW ALL MEN BY THESE PRESENTS THAT PROVIDENCE HEALTH SYSTEM-OREGON, WHO ACQUIRED TITLE AS SISTERS OF PROVIDENCE IN OREGON, IS THE OWNER OF THE LAND DESCRIBED HEREON, AND THEY HAVE CAUSED THIS PARTITION TO BE PREPARED AND THE PROPERTY PARTITIONED IN ACCORDANCE WITH THE OREGON REVISED STATUES, CHAPTER 92.

[signature]
NAME: DANA WHITE
TITLE: EXECUTIVE DIRECTOR, REAL ESTATE/PROPERTY MANAGEMENT
PROVIDENCE HEALTH SYSTEM-OREGON

ACKNOWLEDGMENT

STATE OF OREGON)
)SS
COUNTY OF MULTNOMAH)

APPEARED PERSONALLY BEFORE ME, DANA WHITE FOR PROVIDENCE HEALTH SYSTEM- OREGON, KNOWN TO ME TO BE THE IDENTICAL PERSON WHO EXECUTED THE ABOVE DESCRIBED INSTRUMENT, AND DOES HEREBY ACKNOWLEDGE THE SAME TO BE HER SIGNATURE BEFORE ME THIS 24th DAY July OF 2008.

[signature]
NOTARY SIGNATURE

Glenda L. Fossum-Smith
NOTARY PUBLIC OF OREGON

MY COMMISSION NO.: 420040

MY COMMISSION EXPIRES: 09-18-2011

NOTES:

1. THIS PLAT IS SUBJECT TO THE CONDITIONS IMPOSED BY THE CITY OF PORTLAND IN CASE FILE NUMBER LU NO. 08-120094 LC

*450630

STATUTORY SPECIAL WARRANTY DEED

BOOK 1233 PAGE 1353

Recorded By Pioneer National Title Insurance Company

WESTERN ELECTRIC COMPANY, INCORPORATED, a New York corporation, Grantor, conveys and specially warrants to SISTERS OF PROVIDENCE IN OREGON, a charitable nonprofit Oregon corporation, Grantee, the following described real property free of encumbrances created or suffered by the Grantor except as specifically set forth herein:

PARCEL A - Lots 13, 14, 15, 16, 17 and 18, Block 2, BELGRADE, in the City of Portland, County of Multnomah and State of Oregon.

PARCEL B - A tract of land in Section 31, Township 1 North Range 2 East of the Willamette Meridian, in the City of Portland, County of Multnomah and State of Oregon, described as follows:

Beginning at the Northwest corner of said Section 31 and running thence East along the North line of said Section, 775.5 feet to the Northwest corner of Belgrade, a subdivision; thence South along the center line of the street, along the West line of Belgrade, 468.60 feet to the Southwest corner of Belgrade and the true point of beginning; thence East along the South line of Belgrade, 560.35 feet to the West line of N.E. 47th Avenue; thence South along the West line of N.E. 47th Avenue, 478.05 feet to the Northeasterly right of way line of the Union Pacific Railroad; thence Northwesterly along said right of way line to the East line of Laurelhurst, being the Southerly extension of the West line of Belgrade; thence North 96.03 feet to the true point of beginning.

PARCEL C - Parts of Lots 1, 2, 3, 4 and 5, Block 4, EUCLID HEIGHTS, in the City of Portland, County of Multnomah and State of Oregon, ALSO part of Section 31, Township 1 North, Range 2 East of the Willamette Meridian, in the City of Portland, County of Multnomah and State of Oregon, all of said property being described in its entirety as follows:

Beginning at the Northwest corner of said Block 4, Euclid Heights; thence South 89° 29' East along the North line of said Block 4, a distance of 35 feet; thence South 14.35 feet; thence South 40° 38' 30" East 113.78 feet to the North line of that tract conveyed to Western Electric Company, Incorporated, by deed recorded April 26, 1955 in Book 1719 page 121, Deed Records; thence along said North line South 89° 29' East 161.85 feet to the East line of Lot 1, Block 4, Euclid Heights; thence South 0.5 feet to the Southeast corner of said Lot 1; thence East along the South boundary of Euclid Heights 286 feet to the Northeast corner of that tract conveyed to Western Electric Company, Incorporated, by deed recorded December 14, 1955 in Book 1760 page 243, Deed Records; thence South 219.0 feet to the Southeast corner of said Western Electric tract, being the Northeast corner of that tract conveyed to June F. Davis by deed recorded December 31, 1975 in Book 1080 page 940, Deed Records; thence West along the South line of said Western Electric tract to the Northeasterly right of way line of the Union Pacific Railroad Co.; thence Northwesterly along said right of way line to the West line of said Block 4, Euclid Heights; thence North to the point of beginning.

The above described property is free of all encumbrances created or suffered by the Grantor except

(a) Zoning ordinances and regulations, municipal building restrictions, subdivision regulations and all other laws, ordinances and regulations of any duly constituted public authority having jurisdiction over the property now or hereafter adopted.

(b) Such state of facts as a personal inspection and an accurate survey of the property may disclose, provided the same will not render title unmarketable.

(c) Conditions affecting the property not disclosed by any instrument recorded in the county records.

(d) Roads, ways, easements, liens or encumbrances, including material or labor liens, which are not shown by the public records; mining claims; reservations in patents; the existence of county roads; water rights, water locations, claims or title to water.

(e) Rights or claims of persons in possession, or claiming to be in possession, not shown of record; any state of facts which an accurate survey and inspection of said land would show, provided the same will not render title unmarketable.

(f) Assessments which are not shown as existing liens by the public records; taxes not yet payable; pending proceedings for vacating, opening or changing of streets or highways preceding entry of the ordinance or order therefor.

(g) Any laws, governmental acts or regulations, including but not limited to zoning ordinances, restricting, regulating or prohibiting the occupancy, use or enjoyment of the property or any improvement thereon, limiting the height of improvements, or prohibiting a reduction in the dimensions or area, or separation in ownership, of any lot or parcel of land; or the effect of any violation of any such restrictions, regulations or prohibitions.

(h) Ordinance No. 99667 passed by the Council of the City of Portland, December 16, 1953 and amendment thereto, Ordinance No. 102735 passed September 14, 1955, including the terms and provisions thereof, imposing certain conditions and restrictions and changing the zoning of properties described therein. Certified copies of the above ordinances were recorded February 16, 1954 in PsDeed Book 1644 page 103 and on September 19, 1955 in PsDeed Book 1745 page 445.

(i) An easement created by instrument, including the terms and provisions thereof, dated February 16, 1920, recorded March 7, 1921 in Deed Book 844, page 89 in favor of City of Portland, a municipal corporation, for sewer along the south 4 feet of Lot 13, Block 2, BELGRADE.

(j) Easements for roadway and spur track as granted by deed from The Pacific Telephone and Telegraph Company, a corporation, to Western Electric Company, Incorporated, a corporation, dated June 14, 1932, recorded September 21, 1932 in Book 186 page 521, Deed Records.

(k) Easement for roadway and water main as granted by deed from The Pacific Telephone and Telegraph Company, a California corporation to Western Electric Company, Incorporated, a New York corporation, dated December 31, 1940, recorded March 15, 1941 in Book 594 page 335, Deed Records.

BOOK 12693 PAGE 1855

(l) The right and easement to construct and maintain a sloping embankment for the purpose of eliminating the grade crossing of the Oregon-Washington Railroad and Navigation Company at N. E. 47th Avenue and N. E. Multnomah Street as provided for in Ordinance No. 32094 of the City of Portland.

(m) Terms and covenants in easement from Efem Warehouse Co., an Oregon corporation, to Western Electric Company, Incorporated, a New York corporation, dated May 2, 1950, recorded May 29, 1950, Filing No. 23468.

(n) Any easements or conditions which have arisen since June 29, 1932, provided the same do not render title unmarketable or significantly affect the fair market value of the property, or render the property unsuitable for the intended use.

The true consideration for this conveyance is $2,300,000.

IN WITNESS WHEREOF Grantor has by order of its board of directors caused its name to be signed by its duly authorized officer on January 6, 1978.

WESTERN ELECTRIC COMPANY, INCORPORATED

Attest:

By _____ EXECUTIVE VICE PRESIDENT

_____ Assistant Secretary

STATE OF NEW YORK)
) SS.
COUNTY OF NEW YORK)

The foregoing instrument was acknowledged before me this 6th day of January, 1978, by P E HOGIN who is EXECUTIVE VICE PRESIDENT of Western Electric Company, Incorporated, a New York corporation, on behalf of the corporation.

JOSEPH E. LINS
Notary Public, State of New York
No. 31-4516728
Qualified in New York County
Commission Expires March 30, 19 79

Joseph E Lins
Notary Public for
My commission expires:

Until a change is requested, all tax statements shall be sent to the following address:

Providence Medical Center
700 N. E. 47th Avenue
Portland, Oregon 97213

01899

STATE OF OREGON)
) ss.
Multnomah County)

DEED

1899

I, , Director, Department of Administration Services and Recorder of Conveyances, in and for said County, do hereby certify that the within instrument of writing was received for record and recorded in the record of of said County at

JAN 10 1 09 PM '78

RECORDING SECTION
ADMIN. SERVICES
MULTNOMAH CO., OREGON

DOOK 1233 PAGE 1357

Book 1233 On Page 1353

Witness my hand and seal of office affixed.

Director
Department of Administration
Services

E W [illegible]
Deputy.

Rec-17

MILLER, ANDERSON, NASH, YERKE & WIENER
ATTORNEYS AND COUNSELORS AT LAW
900 S.W. FIFTH AVENUE
PORTLAND, OREGON 97204

1200

Title: 6410 NE Halsey St Ste. 300, Portland, OR, 97213.

After recording return to:

Providence Health System - Oregon
Real Estate and Property Management
4706 NE Glisan
Portland, Oregon 97213

Until a change is requested, all tax statement shall be sent to:

Providence Health System - Oregon
Real Estate and Property Management
4706 NE Glisan
Portland, Oregon 97213

For Recorder's Use Only

Recorded in MULTNOMAH COUNTY, OREGON
C. Swick, Deputy Clerk
A37 5 ATKLM
Total : 41.00

2005-236708 12/07/2005 10:33:21am

STATUTORY WARRANTY DEED

Friedman Investments – Portland, LLC, a California limited liability company ("Grantor"), hereby conveys and warrants to Providence Health System - Oregon, an Oregon nonprofit corporation ("Grantee"), the real property and improvements thereon legally described in **Exhibit A** attached hereto and incorporated herein by this reference (the "Property") subject to only those encumbrances set forth in the attached **Exhibit B**.

The true and actual consideration for this conveyance is $4,700,000.

THIS INSTRUMENT WILL NOT ALLOW USE OF THE PROPERTY DESCRIBED IN THIS INSTRUMENT IN VIOLATION OF APPLICABLE LAND USE LAWS AND REGULATIONS. BEFORE SIGNING OR ACCEPTING THIS INSTRUMENT, THE PERSON ACQUIRING FEE TITLE TO THE PROPERTY SHOULD CHECK WITH THE APPROPRIATE CITY OR COUNTY PLANNING DEPARTMENT TO VERIFY APPROVED USES AND TO DETERMINE ANY LIMITS ON LAWSUITS AGAINST FARMING AND FOREST PRACTICES AS DEFINED IN ORS 30.930.

DATED: December 05, 2005.

Friedman Investments – Portland, LLC, a California limited liability company

By: _____
Name: Michael A. Maidy
Title: Estate Manager

STATE OF California)
: ss
County of Santa Clara)

This instrument was acknowledged before me on December 5th, 2005, by Michael A. Maidy in his/her capacity as Estate Manager of Friedman Investments – Portland, LLC.

SUNITA SINGH
COMM. # 1527555
NOTARY PUBLIC-CALIFORNIA
SANTA CLARA COUNTY
COMM. EXP. NOV. 18, 2008

_____
NOTARY PUBLIC FOR Santa Clara

C:\Documents and Settings\vsahn\Local Settings\Temporary Internet Files\OLK172\Static copy of Statutory Warranty Deed (Prc

"Please see attached California Notary certificate"

FATCO. NO. NCS-180827

5

CALIFORNIA ALL PURPOSE ACKNOWLEDGMENT

State of California

County of Santa Clara } ss

On Dec 5th, 2005 before me, Sunita Singh, Notary Public
Date Name and Title of Officer

personally appeared Michael A. Maidy
Name of Signer(s)

____ personally known to me

__✓__ proved to me on the basis of satisfactory evidence

to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal

SUNITA SINGH
COMM. # 1527555
NOTARY PUBLIC-CALIFORNIA
SANTA CLARA COUNTY
COMM. EXP. NOV. 18, 2008

Signature of Notary Public

Description of Attached Document

Title or Type of Document: Statutory Warranty Deed

Document Date: Dec 5, 2005 Number of Pages: 1

Exhibit A

(Legal Description of the Property)

LEGAL DESCRIPTION

A part of the N.D. Gilham Donation Land Claim, in Section 32, Township 1 North, Range 2 East of the Willamette Meridian, in the City of Portland, County of Multnomah and State of Oregon, described as follows:

Beginning at a point on the North line of Section 32, a distance of 802.56 feet East of the Northwest corner thereof; thence South 0°25'30" East, 30.0 feet to the South line of NE Halsey Street, said point being the true point of beginning of the herein described tract; thence West along said line, 320.59 feet; thence South 0°26'29" East, 678.40 feet to the Northerly right-of-way line of O.W.R. & N. Co.; thence North 52°52'00" East along said right-of-way, 399.64 feet; thence North 0°25'30" West 437.13 feet to the point of beginning.

TOGETHER WITH a nonexclusive easement for ingress, egress and parking as more fully set forth in instrument and in accordance with the terms and provisions thereof, recorded September 21, 1982 in Book 1618, Page 1180, Multnomah County Deed Records.

ALSO TOGETHER WITH a nonexclusive storm sewer line easement as more fully set forth in instrument and in accordance with the terms and provisions thereof, recorded September 21, 1982, Book 1618, Page 1184, Multnomah County Deed Records and also that certain sewer line easement as contained in instrument and in accordance with the terms and provisions thereof, recorded May 28, 1982, Book 1598, Page 1242, Multnomah County Deed Records.

Exhibit B

(Encumbrances from 3rd Updated Preliminary Title Report)

3. The terms and provisions contained in the document entitled "Agreement for Sewer" recorded February 4, 1969 at Book 661, Page 1474 of Official Records.

5. The terms and provisions contained in the document entitled "Declaration of Easement" recorded September 21, 1982 at Book 1618, Page 1184 of Official Records.

6. An easement for ingress and egress and incidental purposes, recorded September 21, 1982 as Fee No. 82-052930 in Book 1618, Page 1180 of Official Records.

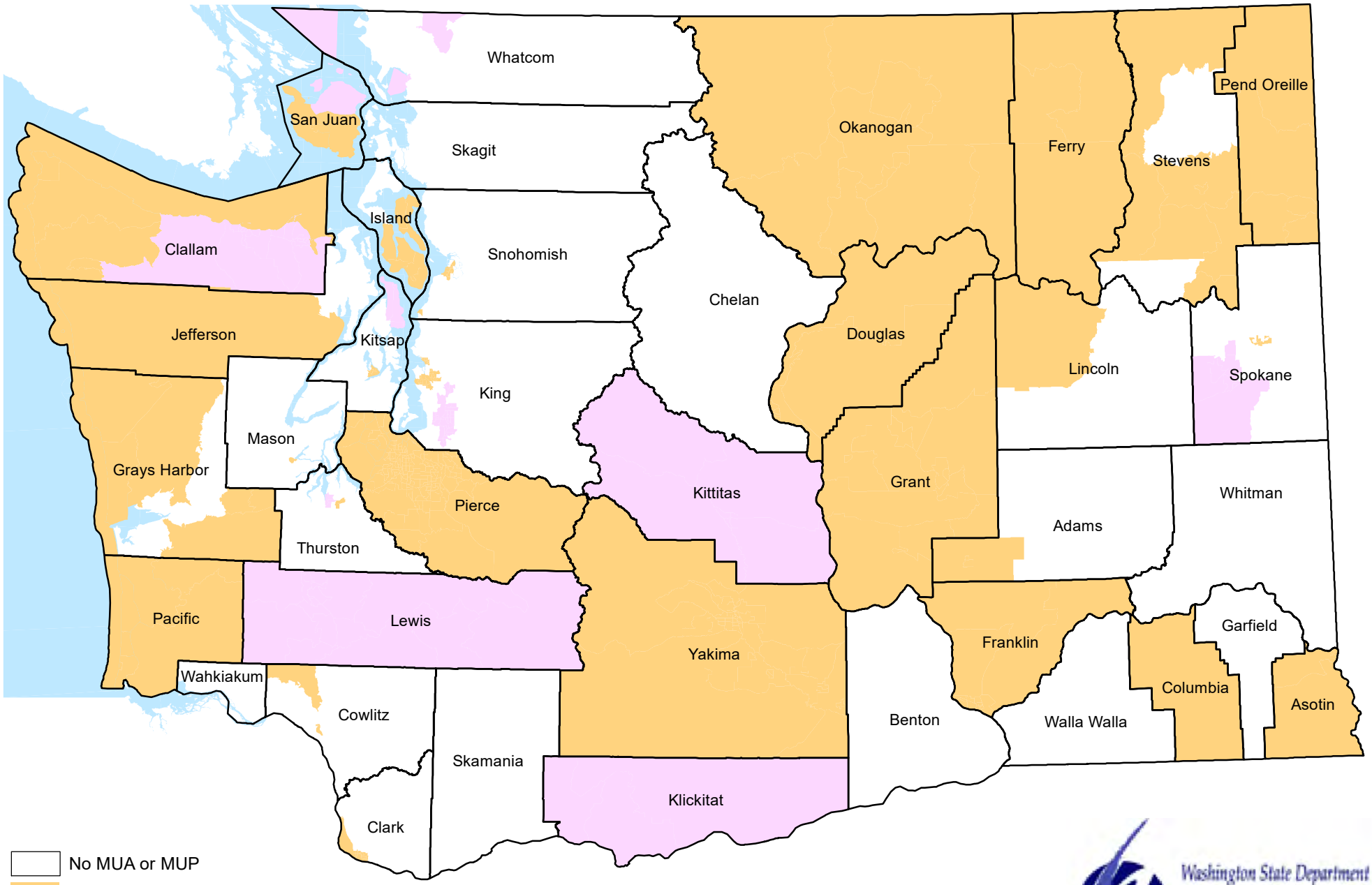
8. An unrecorded lease dated July 1, 1999, executed by Friedman Bag Company, Inc., as lessor, and Sisters of Providence dba Providence Health Systems, as lessee, as disclosed by a Subordination, Non-Disturbance and Attornment Agreement recorded September 21, 2000, as Instrument No. 2000-131749 of Official Records. A document recorded September 21, 2000, as Instrument No. 2000-131749 of Official Records provides that the above document was subordinated to the document recorded September 15, 2000 as Instrument No. 2000-128555 of Official Records.

16. An unrecorded lease, including the terms and provisions, dated November 16, 2001, executed by Friedman Investments – Portland, LLC, as lessor, and Mountain Coin Machine Distributors, Inc., a Nevada corporation, as lessee.

Addendum to Lease, including the terms and provisions thereof dated December, 2001. NOTE: Said Addendum contains a First Right of Refusal, to be eliminated as it relates to this transaction; however, per the terms of the Addendum, it will remain in effect for future transactions.

Exhibit 11
MUA and Facility HPSA Designation for Clark County

Medically Underserved Area & Medically Underserved
May 29, 2019



No MUA or MUP

Medically Underserved Area (MUA)

Medically Underserved Population (MUP)

Designation data from the Office of Community Health Systems.
Designation status changes frequently.
For current information contact Laura Olexa (360) 236-2811.

Washington State Department of Health

Facility HPSA Designation for Clark County

Discipline	Site Name	Site Address	Site City	Site State	Site ZIP Code	Coun	Rural Status
Primary Care	Sea Mar CHC - Battle Ground	118 S Parkway Ave	Battle Ground	WA	98604-9215	Clark	Non-Rural
Primary Care	Sea Mar CHC - Battle Ground NE 189th St.	11117 NE 189th St	Battle Ground	WA	98604-6244	Clark	Non-Rural
Primary Care	Sea Mar CHC - Vancouver 1601 E Fourth Plain Blvd	1601 E Fourth Plain Blvd Bldg 17	Vancouver	WA	98661-3717	Clark	Non-Rural
Primary Care	Sea Mar CHC - Vancouver 317 E 39th St	317 E 39th St	Vancouver	WA	98663-2233	Clark	Non-Rural
Primary Care	Sea Mar CHC - Vancouver 34th St.	19005 SE 34th St	Vancouver	WA	98683-1450	Clark	Non-Rural
Primary Care	Sea Mar CHC - Vancouver 5411 E. Mill Plain Blvd.	5411 E Mill Plain Blvd	Vancouver	WA	98661-7057	Clark	Non-Rural
Primary Care	Sea Mar CHC - Vancouver 7803 NE Fourth Plain Rd.	7803 NE Fourth Plain Blvd	Vancouver	WA	98662-7246	Clark	Non-Rural
Primary Care	Sea Mar CHC - Vancouver Behavioral Health	5501 NE 109th Ct	Vancouver	WA	98662-6177	Clark	Non-Rural
Primary Care	Sea Mar CHC - Vancouver Delaware Lane	7410 Delaware Ln	Vancouver	WA	98664-1408	Clark	Non-Rural
Primary Care	Sea Mar CHC - Vancouver Fourth Plain	6100 NE Fourth Plain Blvd	Vancouver	WA	98661-6830	Clark	Non-Rural
Primary Care	Sea Mar CHC - Vancouver NE 20th Ave.	14508 NE 20th Ave	Vancouver	WA	98686-6424	Clark	Non-Rural
Primary Care	Sea Mar CHC - Vancouver NE 65th St.	11801 NE 65th St	Vancouver	WA	98662-5527	Clark	Non-Rural
Primary Care	Sea Mar CHC - Vancouver NE 88th St.	1412 NE 88th St	Vancouver	WA	98665-9620	Clark	Non-Rural
Mental Health	Sea Mar CHC - Battle Ground	118 S Parkway Ave	Battle Ground	WA	98604-9215	Clark	Non-Rural
Mental Health	Sea Mar CHC - Battle Ground NE 189th St.	11117 NE 189th St	Battle Ground	WA	98604-6244	Clark	Non-Rural
Mental Health	Sea Mar CHC - Vancouver 1601 E Fourth Plain Blvd	1601 E Fourth Plain Blvd Bldg 17	Vancouver	WA	98661-3717	Clark	Non-Rural
Mental Health	Sea Mar CHC - Vancouver 317 E 39th St	317 E 39th St	Vancouver	WA	98663-2233	Clark	Non-Rural
Mental Health	Sea Mar CHC - Vancouver 34th St.	19005 SE 34th St	Vancouver	WA	98683-1450	Clark	Non-Rural
Mental Health	Sea Mar CHC - Vancouver 5411 E. Mill Plain Blvd.	5411 E Mill Plain Blvd	Vancouver	WA	98661-7057	Clark	Non-Rural
Mental Health	Sea Mar CHC - Vancouver 7803 NE Fourth Plain Rd.	7803 NE Fourth Plain Blvd	Vancouver	WA	98662-7246	Clark	Non-Rural
Mental Health	Sea Mar CHC - Vancouver Behavioral Health	5501 NE 109th Ct	Vancouver	WA	98662-6177	Clark	Non-Rural
Mental Health	Sea Mar CHC - Vancouver Delaware Lane	7410 Delaware Ln	Vancouver	WA	98664-1408	Clark	Non-Rural
Mental Health	Sea Mar CHC - Vancouver Fourth Plain	6100 NE Fourth Plain Blvd	Vancouver	WA	98661-6830	Clark	Non-Rural
Mental Health	Sea Mar CHC - Vancouver NE 20th Ave.	14508 NE 20th Ave	Vancouver	WA	98686-6424	Clark	Non-Rural
Mental Health	Sea Mar CHC - Vancouver NE 65th St.	11801 NE 65th St	Vancouver	WA	98662-5527	Clark	Non-Rural
Mental Health	Sea Mar CHC - Vancouver NE 88th St.	1412 NE 88th St	Vancouver	WA	98665-9620	Clark	Non-Rural
Dental Health	Sea Mar CHC - Battle Ground	118 S Parkway Ave	Battle Ground	WA	98604-9215	Clark	Non-Rural
Dental Health	Sea Mar CHC - Battle Ground NE 189th St.	11117 NE 189th St	Battle Ground	WA	98604-6244	Clark	Non-Rural
Dental Health	Sea Mar CHC - Vancouver 1601 E Fourth Plain Blvd	1601 E Fourth Plain Blvd Bldg 17	Vancouver	WA	98661-3717	Clark	Non-Rural
Dental Health	Sea Mar CHC - Vancouver 317 E 39th St	317 E 39th St	Vancouver	WA	98663-2233	Clark	Non-Rural
Dental Health	Sea Mar CHC - Vancouver 34th St.	19005 SE 34th St	Vancouver	WA	98683-1450	Clark	Non-Rural
Dental Health	Sea Mar CHC - Vancouver 5411 E. Mill Plain Blvd.	5411 E Mill Plain Blvd	Vancouver	WA	98661-7057	Clark	Non-Rural
Dental Health	Sea Mar CHC - Vancouver 7803 NE Fourth Plain Rd.	7803 NE Fourth Plain Blvd	Vancouver	WA	98662-7246	Clark	Non-Rural
Dental Health	Sea Mar CHC - Vancouver Behavioral Health	5501 NE 109th Ct	Vancouver	WA	98662-6177	Clark	Non-Rural
Dental Health	Sea Mar CHC - Vancouver Delaware Lane	7410 Delaware Ln	Vancouver	WA	98664-1408	Clark	Non-Rural
Dental Health	Sea Mar CHC - Vancouver Fourth Plain	6100 NE Fourth Plain Blvd	Vancouver	WA	98661-6830	Clark	Non-Rural
Dental Health	Sea Mar CHC - Vancouver NE 20th Ave.	14508 NE 20th Ave	Vancouver	WA	98686-6424	Clark	Non-Rural
Dental Health	Sea Mar CHC - Vancouver NE 65th St.	11801 NE 65th St	Vancouver	WA	98662-5527	Clark	Non-Rural
Dental Health	Sea Mar CHC - Vancouver NE 88th St.	1412 NE 88th St	Vancouver	WA	98665-9620	Clark	Non-Rural
Source: data.HRSA.gov							
Updated: 08/18/2019							

Exhibit 12
DOH Home Health Need Methodology
(Updated October 2019)

DOH Home Health Need Methodology. Updated October 2019

Population Projections – Clark County

County: Clark

source: OFM "Projections of the Population by Age and Sex for Growth Management, 2017 GMA Projections - Medium Series"

Age	2010	2015	2020	2025	2030	2035	2040
Total	**425,363**	**451,820**	**499,398**	**540,343**	**576,880**	**611,968**	**643,551**
0-4	29,429	27,739	30,533	33,103	34,761	35,650	36,127
5-9	31,139	30,868	31,519	33,536	35,893	37,658	38,428
10-14	32,840	32,499	35,160	34,407	36,117	38,642	40,349
15-19	30,021	30,601	33,427	34,913	33,692	35,300	37,696
20-24	24,383	27,866	29,225	30,261	31,356	30,166	31,464
25-29	26,418	26,506	31,238	33,929	34,997	36,040	34,525
30-34	28,467	29,241	34,195	36,676	38,856	39,878	40,714
35-39	29,691	29,668	32,992	37,465	39,689	41,950	42,824
40-44	29,997	30,306	32,610	35,021	39,243	41,660	43,912
45-49	31,452	30,703	32,559	33,988	36,152	40,459	42,957
50-54	30,440	31,812	31,909	33,408	34,584	36,821	41,110
55-59	28,119	31,102	32,202	32,122	33,444	34,621	36,796
60-64	24,257	28,385	29,704	31,585	31,419	32,799	33,993
65-69	16,888	23,646	27,118	29,251	31,028	30,993	32,355
70-74	11,194	16,129	22,762	26,006	28,023	29,918	29,970
75-79	7,916	10,400	14,801	21,028	24,005	26,046	28,061
80-84	6,304	6,948	8,845	12,781	18,300	20,995	23,035
85+	6,408	7,401	8,599	10,863	15,321	22,372	29,235

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
0-64	376,653	378,782	380,910	383,039	385,167	387,296	393,291	399,287	405,282	411,278	417,273	421,901	426,529	431,158	435,786	440,414
65-79	35,998	38,834	41,669	44,505	47,340	50,176	53,077	55,978	58,879	61,780	64,681	67,002	69,323	71,643	73,964	76,285
80+	12,712	13,039	13,366	13,694	14,021	14,348	14,967	15,587	16,206	16,825	17,444	18,684	19,924	21,164	22,404	23,644
Total	425,363	430,654	435,946	441,237	446,529	451,820	461,336	470,851	480,367	489,882	499,398	507,587	515,776	523,965	532,154	540,343

Source: DOH Need Home Health Need Methodology (October, 2019)

Existing Agencies – Clark County

Agency	License Number	CON Approved	Counties with CON approval	Counties Served
Seattle Childrens Hospital Home Care Services	IHS.FS.00000097	No		Clark, Klickitat, Skamania
Ashley House	IHS.FS.00000227	No		Clark, Klickitat, Skamania
Maxim Healthcare Services	IHS.FS.00000375	No		Clark, Skamania
Popes Kids Place	IHS.FS.60083889	No		Clark, Klickitat, Skamania
United Energy Workers Healthcare, Corp	IHS.FS.60593988	No		Clark, Klickitat, Skamania
Ro Health	IHS.FS.60610351	No		Clark
Nuclear Care Partners LLC	IHS.FS.60670421	No		Clark, Klickitat, Skamania
Beam for Seniors - Bridge Park, Seattle, WA	IHS.FS.60674651	No		Clark
Community Home Health and Hospice	IHS.FS.00000262	Yes	Clark	Clark
Kindred at Home	IHS.FS.00000300	Yes	Clark	Clark
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Yes	Clark, Skamania	Clark, Skamania
Aveanna Healthcare (Pediatric Services of America)	IHS.FS.00000422	Yes	Clark	Clark
Touchmark Home Health	IHS.FS.00000454	Yes	Clark	Clark
PeaceHealth Hospice and PeaceHealth Homecare	IHS.FS.60331226	Yes	Clark	Clark
Healthy Living at Home - Vancouver LLC	IHS.FS.60814521	Yes	Clark	Clark
Total Home Health Agencies in Clark County: 15				
Total M/M Certified in Clark County: 7				

Source: DOH Need Home Health Need Methodology (October, 2019)

1987 State Health Plan Methodology – Clark County

2020	Age Cohort	*	County Population	*	SHP Formula	*	Number of Visits	=	Projected Number of Visits
	0-64		417,273		0.005		10		20,864
	65-79		64,681		0.044		14		39,843
	80+		17,444		0.183		21		67,037
							TOTAL:		**127,744**
							Number of Expected Visits per Agency		*10,000*
							Projected Number of Needed Agencies		**12.77**

2021	Age Cohort	*	County Population	*	SHP Formula	*	Number of Visits	=	Projected Number of Visits
	0-64		421,901		0.005		10		21,095
	65-79		67,002		0.044		14		41,273
	80+		18,684		0.183		21		71,803
							TOTAL:		**134,171**
							Number of Expected Visits per Agency		*10,000*
							Projected Number of Needed Agencies		**13.42**

2022	Age Cohort	*	County Population	*	SHP Formula	*	Number of Visits	=	Projected Number of Visits
	0-64		426,529		0.005		10		21,326
	65-79		69,323		0.044		14		42,703
	80+		19,924		0.183		21		76,568
							TOTAL:		**140,597**
							Number of Expected Visits per Agency		*10,000*
							Projected Number of Needed Agencies		**14.06**

Source: DOH Need Home Health Need Methodology (October, 2019)

Exhibit 13
Providence Home Health Patient Origin by Zip Code

Providence Home Health Patient Origin by Zip code (Q1 2019)

Clackamas	
Zipcode	Number
97004	7
97009	31
97011	7
97013	62
97015	145
97022	69
97023	82
97027	8
97034	2
97035	27
97045	4
97055	44
97067	4
97068	1
97070	1
97086	2
97089	6
97222	10
97267	31
Total	**543**

Clatsop	
Zipcode	Number
97102	67
97103	67
97110	1
97121	25
97138	42
97146	4
Total	**206**

Polk	
Zipcode	Number
97347	28
Total	**28**

Wasco	
Zipcode	Number
97040	9
97058	83
Total	**92**

Columbia	
Zipcode	Number
97016	7
97051	4
97053	100
97056	18
Total	**129**

Tillamook	
Zipcode	Number
97131	1
Total	**1**

Hood River	
Zipcode	Number
97014	3
97031	28
97041	6
97044	10
Total	**47**

Yamhill	
Zipcode	Number
97111	24
97114	71
97115	70
97127	12
97128	46
97132	87
97148	4
97378	8
97396	4
Total	**326**

Marion	
Zipcode	Number
97002	17
97020	31
97032	1
97137	35
Total	**84**

Multnomah	
Zipcode	Number
97019	37
97024	28
97030	30
97060	50
97080	15
97201	2
97202	64
97203	1
97204	3
97205	2
97206	6
97209	7
97210	5
97211	7
97212	47
97213	2
97214	3
97215	6
97216	58
97217	145
97218	5
97219	68
97220	4
97221	103
97227	4
97230	3
97231	66
97232	39
97233	37
97236	12
97239	19
97266	49
Total	**927**

Washington	
Zipcode	Number
97003	22
97005	6
97006	35
97007	29
97008	41
97062	19
97078	26
97106	40
97109	28
97113	20
97116	39
97117	62
97119	22
97123	77
97124	73
97133	50
97140	72
97223	5
97224	106
97225	87
97229	3
Total	**862**

Source: Providence

Exhibit 14
Providence Home Health Patients Served by Service Type and County

Providence Home Health patients receiving skilled services by type and county (2019 annualized)

Clackamas	
Services	**# of Patients**
Skilled Nursing	2,760
Physical Therapy	3,024
Occupational Health	1,716
Speech Therapy	336
Medical Social Work	636
Home Health Aid	412
Chaplain	4

Clatsop	
Services	**# of Patients**
Skilled Nursing	784
Physical Therapy	756
Occupational Health	480
Speech Therapy	136
Medical Social Work	128
Home Health Aid	172
Chaplain	4

Columbia	
Services	**# of Patients**
Skilled Nursing	200
Physical Therapy	136
Occupational Health	124
Speech Therapy	24
Medical Social Work	32
Home Health Aid	12

Hood River	
Services	**# of Patients**
Skilled Nursing	324
Physical Therapy	312
Occupational Health	188
Speech Therapy	16
Medical Social Work	32
Home Health Aid	20

Marion	
Services	**# of Patients**
Skilled Nursing	56
Physical Therapy	68
Occupational Health	40
Speech Therapy	12
Medical Social Work	4
Home Health Aid	8

Multnomah	
Services	**# of Patients**
Skilled Nursing	4,496
Physical Therapy	4,868
Occupational Health	3,100
Speech Therapy	648
Medical Social Work	1,004
Home Health Aid	852

Polk	
Services	**# of Patients**
Skilled Nursing	20
Physical Therapy	20
Occupational Health	4
Medical Social Work	4
Home Health Aid	4

Tillamook	
Services	**# of Patients**
Skilled Nursing	12
Physical Therapy	16
Occupational Health	12
Speech Therapy	4

Yamhill	
Services	**# of Patients**
Skilled Nursing	1,228
Physical Therapy	1,096
Occupational Health	552
Speech Therapy	248
Medical Social Work	320
Home Health Aid	152

Washington	
Services	**# of Patients**
Skilled Nursing	4,444
Physical Therapy	4,396
Occupational Health	2,604
Speech Therapy	544
Medical Social Work	704
Home Health Aid	916
Dietician	4

Wasco	
Services	**# of Patients**
Skilled Nursing	44
Physical Therapy	52
Occupational Health	44
Speech Therapy	4
Medical Social Work	4
Home Health Aid	8

Notes:

1) Data provided does not illustrate unduplicated or unique patients.

2) a single unique patient may have been provided with more than one service type during the period.

3) 3 months of data (June, July, August, 2019) is annualized for 2019.

Exhibit 15
Admission Criteria Policy

Origination:	*10/1979*
Effective:	*06/2019*
Last Approved:	*06/2019*
Last Revised:	*04/2017*
Next Review:	*06/2021*
Owner:	*Lisa Ludwig: Coord-Proj*
Area:	*Assessment, Documentation Standards & Orders*
References:	
Applicability:	*OR - Home Health (HH)*

Admission Criteria HH 207-1

JCAHO: MM 1.10, PC.1.10

SUMMARY OF CHANGES: no changes

OBJECTIVE

To provide written documentation of the conditions surrounding the acceptance of patients for Home Health service.

POLICY

A. Admission for service through Home Health (HH) is based on the medical, nursing and social information provided by the physician. Any patient of any age meeting the following criteria for HH service under the direction and written orders of the attending physician may receive service.

1. A patient must have a physician who
    a. is a doctor of medicine, osteopathy or podiatry legally authorized to practice medicine and surgery by the State in which such function or action is performed;
    b. is available at all times during operating hours; and
    c. participates in the establishment and periodic review of a written plan of care
    d. Providers for traditional Medicare patients are required to be PECOS enrolled.
2. Skilled services and homebound status are considered to determine appropriateness for admission to HH.
3. HH service personnel and resources are adequate and suitable to provide the services ordered by the physician for the patient.
4. The patient and family are cooperative and willing to participate with HH Services.
5. There must be a reasonable expectation that the patient's health will be benefited by care at home as distinguished from care in a hospital or extended care facility.
6. Equipment, supplies, and pharmaceutical products are available at the time of admission to meet patient/client needs
7. Patient's place of residence or surrounding area does not pose a safety hazard or security risk to staff.

8. Patient resides within the defined service area for HH.

B. If the referral has been accepted, and then it is determined that a person did not qualify for Home Health services, the person and physician will be notified promptly.

C. If Providence HH is unable to meet patient needs, a referral will be made for services as available elsewhere, upon physician approval.

REFERENCES

A. HS 100-2 Geographic Area Served

Attachments:

Approval Signatures

Approver	Date
Lisa Ludwig: Coord-Proj	06/2019
Susan Murtha: Exec Dir-Home Hlth	06/2019
Janis Picker: Mgr-qual/Clinical Educ	06/2019
Lisa Ludwig: Coord-Proj	06/2019

Applicability

OR - Home Health (HH)

Exhibit 16
Admission Process Policy

Current Status: *Active* **PolicyStat ID:** *6171182*

Origination:	*10/1979*
Effective:	*04/2019*
Last Approved:	*04/2019*
Last Revised:	*04/2019*
Next Review:	*04/2021*
Owner:	*Lisa Ludwig: Coord-Proj*
Area:	*Assessment, Documentation Standards & Orders*
References:	
Applicability:	*OR - Home Health (HH)*

Admission Process HH 207-2

SUMMARY OF CHANGES: Minor updates made

OBJECTIVE

A. To define the process by which the appropriate and necessary information will be assessed, analyzed and utilized for care-based decisions by qualified individuals at the time of admission.

B. To assure that all patients receive the necessary care within the time frame it is needed.

POLICY

A. Once it is determined that a patient meets the Admission Criteria and is appropriate for Home Health, the admission to service will begin.

B. All patients who accept admission to Home Health shall be assessed within forty-eight (48) hours of the receipt of the referral or as specified by the physician. The secondary service (any discipline beyond the admitting discipline) contact to the patient will be made within 72 hours. The physician will be informed by phone call or written communication if the initial visit for any discipline is changed.

PROCEDURE

A. The referral is started in Access Services for the Portland service area and North Coast. Referrals for the Gorge are handled by the Gorge office. The admitting process ensures that Home Health has the following information at the time of referral/admission:

1. Attending physician name, address, and telephone number
2. Patient's address
3. Patient's working contact number
4. Patient's admitting diagnosis
5. History and Physical as possible
6. Current orders for Home Health Services
7. Insurance information

B. In determining the appropriate hour to make the home visit, such factors as physician's instructions, knowledge of patient needs, and geographic area will be given consideration. All admission visits will be

preceded by a phone call to the patient to agree upon an appointed time.

C. When multidisciplinary services are ordered at the initial referral the scheduler will schedule all disciplines.

REFERENCES

A. HH Policy Nursing Responsibilities

B. HS Policy Physical Therapy Services

C. HS Policy Home Health Aide Service

D. HS Policy Medical Social Work Service

E. HS Policy Occupational Therapy Service

F. HS Policy Speech and Language Pathology Service

G. HS Policy Mental Health

Attachments:

Approval Signatures

Approver	Date
Lisa Ludwig	04/2019
Susan Murtha: Dir-Home Hlth	03/2019
Janis Picker: Manager HH QM/Education	03/2019
Lisa Ludwig	03/2019

Applicability

OR - Home Health (HH)

Exhibit 17
Financial Assistance Patient Services Policy

Origination:	*01/1995*
Effective:	*06/2018*
Last Approved:	*06/2018*
Last Revised:	*06/2018*
Next Review:	*06/2020*
Owner:	*Michael Gustafson: Quality Analyst*
Area:	*Administration*
References:	
Applicability:	*Providence OR - Home Services*

Financial Assistance Patient Services HS 101-2

SUMMARY OF CHANGES: numerous updates made throughout, this policy should be reviewed completely.

OBJECTIVE

To outline the circumstances under which charity care discounts may be provided to qualifying low income patients for medically necessary healthcare services provided by Providence Home Services.

POLICY

A. Providence Home Services will follow eligibility criteria and procedures outlined in OR Charity Care Policy 515.00. This policy also applies to Home Services patients that reside in Washington..

B. In order to minimize patient /provider/staff duplication of effort and to expedite patient care, Providence Home Services will accept Financial Assistance determinations made by PHS- One Revenue Cycle. The patient will be held accountable for the cost of all services until the patient has fulfilled the Oregon Charity Care Policy requirements related to their financial capabilities and has been approved for financial assistance or deemed to qualify under the compassionate needs assistance or indigence assistance.

C. Providence Home Services will redirect referral sources from other health systems that request financial assistance for their patients, back to their own system if their system provides this service. This does not include patients referred from PHS hospitals or employed physicians or those health systems with which Providence Home Services has a contractual or special relationship.

D. This policy does not apply to Providence Care Choices participants since they must be a Medicare recipient to be eligible for the service.

Service Criteria for all Home Services business lines:

A. 1. The patient will be held accountable for the cost of all services until the patient has fulfilled the PHS-OR Financial Assistance Policy requirements related to their financial capabilities and has been approved for financial assistance. No more than 30 days will be granted for the patient to have

completed the Financial Assistance Policy requirements.

2. Service criteria determinations for urgent requests will be made within 24 hours of receiving key patient data required to make the determination. Urgent requests are defined as requests for equipment necessary to facilitate patient transition from hospital to home and medically necessary to establish a safe home environment required to support the patient's current health status.

3. Products and Services - Home Services limits its products provided under financial assistance to the following

   Home Medical Equipment:

   a. HME will limit its provision of equipment to patient living conditions in which HME is confident it has the opportunity to retrieve the equipment.

   b. HME will limit its provision of equipment to patient living conditions that are safe and conducive to the intended medical use of the equipment.

   c. HME will make the determination of "most cost effective" and appropriate equipment/supply/service to be provided.

   d. HME will not provide custom or special order products under financial assistance.

   e. Standard and heavy-duty semi-electric beds, patient lifts, wheelchairs, commodes and walkers. Stationary oxygen systems (non-portable), standard CPAP/BIPAP, nebulizers, intermittent gastric suction, enteral feeding, diabetic strips and lancets for insulin dependent patients only and diabetic supplies prior to birth for gestational diabetic women. The decision to provide accessories to the above products will be made by the HME Director or their designee based on the medical necessity of the accessory and/or other equipment.

   f. Infusion/Specialty Pharmacy:

      Nursing services external to Providence Home Services will not be provided

      i. Only formulary drugs and supplies will be provided.

      ii. Infusion/Specialty Pharmacy will make the determination of the "most cost effective" and appropriate equipment for medication administration.

      iii. Infusion/Specialty Pharmacy will limit its provision of equipment to patient living conditions in which Infusion/Specialty Pharmacy is confident it has the opportunity to retrieve the equipment.

      iv. Ongoing nursing care of non-homebound patients will be done in the Providence HS Infusion/Specialty Pharmacy Suites.

   g. Home Health and Hospice

      The patient will be held accountable for the cost of all services until the patient has fulfilled the PHS-OR Financial Assistance Policy requirements related to their financial capabilities and has been approved for financial assistance. No more than 30 days will be granted for the patient to have completed the Financial Assistance

      i. Service criteria determinations for urgent requests will be made within 24 hours of receiving

key patient data required to make the determination. Urgent requests are defined as requests for services necessary to facilitate patient transition from hospital to home care to support the patient's current health status

Duration:

a. The initial duration of approved assistance may vary depending upon each situation, but not to exceed six months, however patients with fixed income like social security are generally approved for 12 months.

b. One time assistance: covers one account for a pre-determined date span.

ii. REFERENCES

B. Providence Home Services HME Financial Assistance Process Flow

C. OR Charity Care Policy

D. HS 1000-5 Financial Disclosure

MMIS CODES

BMD	OHP WITH LIMITED DRUG
BMH	OHP PLUS
KIT	OHP STANDARD
CWM	CAWEM (review for charity, no DME)
CWX	CAWEM PLUS
MED	QUALIFIED MEDICARE BENEFICIARY (QMB)
BMM	QMB PLUS OHP WITH LIMITED DRUG
ADMIN	PENDING OHP PLUS

FA COVERED ITEMS

STANDARD & HEAVY-DUTY SEMI-ELECTRIC BEDS AND RAILS
PATIENT LIFTS
TRAPEZE BARS
TRANSFER BENCHES
BATH BENCHES
WHEELCHAIRS (STANDARD) CAN INCLUDE FOOT AND LEG-RESTS
COMMODES (INCLUDES BUCKET W/COMMODE)
VERSA FRAMES
STANDARD WALKERS (W/OR WITHOUT WHEELS)
STATIONARY OXYGEN SYSTEMS (NON-PORTABLE) *SAT LEVELS BELOW 89%*
STANDARD CPAP'S /BIPAP'S W/HUMIDIFIER (IF NEEDED)
NEBULIZERS
INTERMITTENT GASTRIC SUCTION
ENTERAL FEEDING (FOOD, PUMP, IV POLE, TUBING, ETC...)
DIABETIC STRIPS, LANCETS, & SYRINGES
(INSULIN DEPENDENT AND GESTATIONAL DIABETIC PT'S ONLY)

NETWORK SERVICES ARE NEVER COVERED.

Approval Signatures

Approver	Date
Michael Gustafson: Quality Analyst	06/2018

Applicability

OR - Clinical Support Staff (CSS), OR - Connections, OR - Credena Health (CH), OR - Home Health (HH), OR - Home Medical Equipment (HME), OR - Home Services, OR - Home Services Pharmacy (HSRx), OR - Hospice (HO)

Exhibit 18
Providence Home Health Revenue and Expense Proforma
&
Assumptions and Start-up Costs

Providence Home Health Proforma Forecast, July 2020 – 2023

The Project (*Clark County Only*)

Revenue and Expense Statement

	Jul - Dec 2020	2021	2022	2023
	Forecast			
Home Visits	**3,000**	**7,500**	**9,000**	**10,000**
GROSS PATIENT REVENUE				
Medicare Fee for Service	241,896	604,740	725,688	806,320
Medicare Managed Care	423,547	1,058,865	1,270,638	1,411,820
Medicaid	6,002	15,008	18,009	20,010
Medicaid Managed Care	72,068	180,173	216,207	240,230
Commercial	70,168	175,418	210,501	233,890
Other	5,455	13,635	16,362	18,180
Self Pay	686	1,718	2,061	2,290
TOTAL GROSS PATIENT REVENUE	**819,823**	**2,049,555**	**2,459,466**	**2,732,740**
DEDUCTIONS FROM REVENUE				
Medicare Fee for Service	16,497	41,243	49,491	54,990
Medicare Managed Care	22,300	55,748	66,897	74,330
Medicaid	2,193	5,483	6,579	7,310
Medicaid Managed Care	31,170	77,925	93,510	103,900
Commercial	20,806	52,013	62,415	69,350
Other	1,792	4,478	5,373	5,970
Self Pay	75	188	225	250
TOTAL CONTRACTUAL ALLOWANCES	**94,833**	**237,075**	**284,490**	**316,100**
Bad Debt	2,869	7,173	8,608	9,565
Charity Care	4,429	11,074	13,288	14,765
TOTAL DEDUCTIONS FROM REVENUE	**102,132**	**255,322**	**306,386**	**340,429**
NET PATIENT REVENUE				
Medicare Fee for Service	225,400	563,498	676,197	751,330
Medicare Managed Care	401,247	1,003,118	1,203,741	1,337,490
Medicaid	3,809	9,525	11,430	12,700
Medicaid Managed Care	40,899	102,248	122,697	136,330
Commercial	49,362	123,405	148,086	164,540
Other	3,663	9,158	10,989	12,210
Self Pay/Charity	(6,688)	(16,717)	(20,060)	(22,289)
TOTAL NET PATIENT REVENUE	**717,691**	**1,794,233**	**2,153,080**	**2,392,311**
TOTAL NET OPERATING REVENUE	**717,691**	**1,794,233**	**2,153,080**	**2,392,311**
OPERATING EXPENSES				
Salary and Wages	343,266	876,454	1,102,962	1,251,074
Benefits	94,398	241,025	303,314	344,045
Supplies	15,031	35,475	42,570	47,300
Purchased Services	48,622	69,998	83,998	93,331
Other Expenses	27,516	62,175	74,610	82,900
TOTAL OPERATING EXPENSES	**528,833**	**1,285,127**	**1,607,454**	**1,818,651**
NON-OPERATING EXPENSES				
System Allocation	50,238	125,596	150,716	167,462
TOTAL NON-OPERATING EXPENSES	**50,238**	**125,596**	**150,716**	**167,462**
TOTAL EXPENSES	**579,071**	**1,410,724**	**1,758,169**	**1,986,112**
NET OPERATING INCOME (LOSS)	**138,619**	**383,509**	**394,910**	**406,198**
NOI %	**19.3%**	**21.4%**	**18.3%**	**17.0%**

Source: Providence

Providence Home Health Proforma Forecast, July 2020 – 2023

The Project (*Clark County Only*)

Expense Statement

	Jul - Dec 2020	2021	2022	2023
	Forecast			
Home Visits	3,000	7,500	9,000	10,000
SALARIES & BENEFITS				
Registered Nurse (RN)	159,254	395,351	478,876	532,332
LPN	-	-	-	-
Home Health Aide	7,419	17,723	21,432	23,905
Administrative and Clerical	24,439	48,878	61,097	73,317
Physical Therapist (PT)	98,704	248,170	297,992	330,894
Occupational Therapist (OT)	36,415	91,037	109,244	122,660
Social Worker (MSW)	7,435	17,349	20,653	23,132
Speech Therapist (ST)	9,600	24,000	28,800	31,680
Management/Supervisor	-	33,946	84,866	113,154
Employee Benefits	94,398	241,025	303,314	344,045
TOTAL SALARIES & BENEFITS	**437,664**	**1,117,479**	**1,406,276**	**1,595,120**
SUPPLIES				
Medical Supplies	14,406	34,425	41,310	45,900
Non Medical Supplies	126	300	360	400
Pharmacy Supplies	53	150	180	200
Office Supplies	372	450	540	600
Other Supplies	74	150	180	200
TOTAL SUPPLIES	**15,031**	**35,475**	**42,570**	**47,300**
PURCHASED SERVICES				
Management Fees	18,672	46,650	55,980	62,200
Print and Publications	2,360	3,075	3,690	4,100
Advertising and Marketing	759	23	28	31
Telephone and Wireless	2,881	7,200	8,640	9,600
Translation Services	2,111	5,250	6,300	7,000
Maintenance Services	198	525	630	700
Other Purchased Services	21,641	7,275	8,730	9,700
TOTAL PURCHASED SERVICES	**48,622**	**69,998**	**83,998**	**93,331**
OTHER EXPENSES				
Mileage	14,793	36,975	44,370	49,300
Travel	239	600	720	800
Training & Education	347	900	1,080	1,200
Equipment (PC, Printers, etc.)	3,438	3,600	4,320	4,800
Dues and Memberships	37	75	90	100
Lease Expense	7,694	19,200	23,040	25,600
Equipment Lease	108	300	360	400
Licensing	763	300	360	400
Other Miscellaneous Expenses	97	225	270	300
TOTAL OTHER EXPENSES	**27,516**	**62,175**	**74,610**	**82,900**
TOTAL OPERATING EXPENSES	**528,833**	**1,285,127**	**1,607,454**	**1,818,651**
NON-OPERATING EXPENSES				
Allocated System Expense	50,238	125,596	150,716	167,462
TOTAL NON-OPERATING EXPENSES	**50,238**	**125,596**	**150,716**	**167,462**
TOTAL EXPENSES	**579,071**	**1,410,724**	**1,758,169**	**1,986,112**

Source: Providence

Providence Home Health Proforma Forecast, 2020 – 2023

Without Project

Revenue and Expense Statement

	2020	2021	2022	2023
	Forecast	Forecast	Forecast	Forecast
Home Visits	**257,198**	**262,342**	**267,589**	**272,941**
GROSS PATIENT REVENUE (GPR)				
Medicare Fee for Service	20,738,443	21,153,190	21,576,254	22,007,779
Medicare Managed Care	36,311,903	37,038,020	37,778,781	38,534,356
Medicaid	514,563	524,947	535,446	546,155
Medicaid Managed Care	6,178,627	6,302,251	6,428,296	6,556,862
Commercial	6,015,672	6,135,926	6,258,644	6,383,817
Other	467,681	476,938	486,477	496,207
Self Pay	58,817	60,076	61,278	62,503
TOTAL GROSS PATIENT REVENUE	**70,285,706**	**71,691,348**	**73,125,175**	**74,587,679**
DEDUCTIONS FROM REVENUE				
Medicare Fee for Service	1,414,310	1,442,621	1,471,473	1,500,903
Medicare Managed Care	1,911,876	1,949,991	1,988,991	2,028,770
Medicaid	188,029	191,772	195,608	199,520
Medicaid Managed Care	2,672,261	2,725,737	2,780,252	2,835,857
Commercial	1,783,749	1,819,344	1,855,731	1,892,846
Other	153,668	156,618	159,751	162,946
Self Pay	6,441	6,559	6,690	6,824
TOTAL CONTRACTUAL ALLOWANCES	**8,130,333**	**8,292,642**	**8,458,495**	**8,627,665**
Bad Debt	246,000	250,920	255,938	261,057
Charity Care	379,750	387,345	395,091	402,993
TOTAL DEDUCTIONS FROM REVENUE	**8,756,083**	**8,930,907**	**9,109,525**	**9,291,715**
NET PATIENT REVENUE				
Medicare Fee for Service	19,324,133	19,710,569	20,104,781	20,506,876
Medicare Managed Care	34,400,027	35,088,029	35,789,790	36,505,586
Medicaid	326,534	333,175	339,838	346,635
Medicaid Managed Care	3,506,366	3,576,514	3,648,044	3,721,005
Commercial	4,231,923	4,316,581	4,402,913	4,490,971
Other	314,013	320,320	326,726	333,261
Self Pay/Charity	(573,374)	(584,746)	(596,441)	(608,370)
TOTAL NET PATIENT REVENUE	**61,529,623**	**62,760,442**	**64,015,651**	**65,295,964**
Other Operating Revenue	722,728	737,182	751,926	766,964
TOTAL NET OPERATING REVENUE	**62,252,350**	**63,497,624**	**64,767,576**	**66,062,928**
OPERATING EXPENSES				
Salary and Wages	38,251,602	39,016,634	39,796,967	40,592,906
Benefits	10,391,056	10,598,877	10,810,854	11,027,071
Supplies	1,216,538	1,240,879	1,265,697	1,291,011
Purchased Services	2,402,793	2,448,468	2,497,437	2,547,386
Other Expenses	2,132,710	2,174,818	2,218,315	2,262,681
TOTAL OPERATING EXPENSES	**54,394,699**	**55,479,676**	**56,589,270**	**57,721,055**
NON-OPERATING EXPENSES				
Depreciation	1,055	-	-	-
System Allocation	4,357,665	4,444,834	4,533,730	4,624,405
TOTAL NON-OPERATING EXPENSES	**4,358,719**	**4,444,834**	**4,533,730**	**4,624,405**
TOTAL EXPENSES	**58,753,419**	**59,924,510**	**61,123,000**	**62,345,460**
NET OPERATING INCOME (LOSS)	**3,498,932**	**3,573,114**	**3,644,576**	**3,717,468**
NOI %	5.6%	5.6%	5.6%	5.6%

Source: Providence

Providence Home Health Proforma Forecast, 2020 – 2023

Without Project

Expense Statement

	2020	2021	2022	2023
	Forecast	Forecast	Forecast	Forecast
Home Visits	**257,198**	**262,342**	**267,589**	**272,941**
SALARIES & BENEFITS				
Registered Nurse (RN)	16,216,737	16,541,071	16,871,893	17,209,331
LPN	762,407	777,655	793,208	809,072
Home Health Aide	636,325	649,051	662,032	675,273
Administrative and Clerical	3,164,027	3,227,308	3,291,854	3,357,691
Physical Therapist (PT)	8,529,610	8,700,202	8,874,206	9,051,690
Occupational Therapist (OT)	3,380,612	3,448,224	3,517,189	3,587,532
Social Worker (MSW)	780,976	796,596	812,528	828,778
Speech Therapist (ST)	1,037,563	1,058,314	1,079,480	1,101,070
Management/Supervisor	3,155,711	3,218,826	3,283,202	3,348,866
Other	121,690	124,123	126,606	129,138
Agency	465,945	475,264	484,769	494,465
Employee Benefits	10,391,056	10,598,877	10,810,854	11,027,071
TOTAL SALARIES & BENEFITS	**48,642,658**	**49,615,511**	**50,607,821**	**51,619,978**
SUPPLIES				
Medical Supplies	1,180,100	1,204,151	1,228,234	1,252,799
Non Medical Supplies	10,836	10,494	10,704	10,918
Pharmacy Supplies	4,543	5,247	5,352	5,459
Office Supplies	14,754	15,741	16,055	16,376
Other Supplies	6,306	5,247	5,352	5,459
TOTAL SUPPLIES	**1,216,538**	**1,240,879**	**1,265,697**	**1,291,011**
PURCHASED SERVICES				
Management Fees	1,600,784	1,631,770	1,664,405	1,697,693
Print and Publications	105,842	107,560	109,712	111,906
Advertising and Marketing	790	813	830	846
Telephone and Wireless	247,035	251,849	256,886	262,023
Translation Services	180,947	183,640	187,312	191,059
Maintenance Services	16,933	18,364	18,731	19,106
Other Purchased Services	250,462	254,472	259,562	264,753
TOTAL PURCHASED SERVICES	**2,402,793**	**2,448,468**	**2,497,437**	**2,547,386**
OTHER EXPENSES				
Mileage	1,268,272	1,293,348	1,319,215	1,345,599
Travel	20,484	20,987	21,407	21,835
Training & Education	29,731	31,481	32,111	32,753
Equipment (PC, Printers, etc)	123,242	125,924	128,443	131,012
Dues and Memberships	3,208	2,623	2,676	2,729
Lease Expense	659,637	671,596	685,028	698,729
Equipment Lease	9,302	10,494	10,704	10,918
Licensing	10,535	10,494	10,704	10,918
Other Miscelleneous Expenses	8,300	7,870	8,028	8,188
TOTAL OTHER EXPENSES	**2,132,710**	**2,174,818**	**2,218,315**	**2,262,681**
TOTAL OPERATING EXPENSES	**54,394,699**	**55,479,676**	**56,589,270**	**57,721,055**
NON-OPERATING EXPENSES				
Depreciation	1,055	-	-	-
Allocated System Expense	4,357,665	4,444,834	4,533,730	4,624,405
TOTAL NON-OPERATING EXPENSES	**4,358,719**	**4,444,834**	**4,533,730**	**4,624,405**
TOTAL EXPENSES	**58,753,419**	**59,924,510**	**61,123,000**	**62,345,460**

Source: Providence

Providence Home Health Proforma Forecast, 2020 – 2023

With Project

Revenue and Expense Statement

	2020	2021	2022	2023
	Forecast	Forecast	Forecast	Forecast
Home Visits	**260,198**	**269,842**	**276,589**	**282,941**
GROSS PATIENT REVENUE				
Medicare Fee for Service	20,980,340	21,757,930	22,301,942	22,814,099
Medicare Managed Care	36,735,451	38,096,885	39,049,419	39,946,176
Medicaid	520,565	539,955	553,455	566,165
Medicaid Managed Care	6,250,696	6,482,423	6,644,503	6,797,092
Commercial	6,085,840	6,311,343	6,469,145	6,617,707
Other	473,136	490,573	502,839	514,387
Self Pay	59,503	61,794	63,339	64,793
TOTAL GROSS PATIENT REVENUE	**71,105,529**	**73,740,903**	**75,584,641**	**77,320,419**
DEDUCTIONS FROM REVENUE				
Medicare Fee for Service	1,430,807	1,483,863	1,520,964	1,555,893
Medicare Managed Care	1,934,177	2,005,738	2,055,888	2,103,100
Medicaid	190,222	197,255	202,187	206,830
Medicaid Managed Care	2,703,430	2,803,662	2,873,762	2,939,757
Commercial/Other	1,804,555	1,871,357	1,918,146	1,962,196
Other	155,460	161,096	165,124	168,916
Self Pay	6,516	6,746	6,915	7,074
TOTAL CONTRACTUAL ALLOWANCES	**8,225,167**	**8,529,717**	**8,742,985**	**8,943,765**
Bad Debt	248,869	258,093	264,546	270,621
Charity Care	384,179	398,418	408,380	417,758
TOTAL DEDUCTIONS FROM REVENUE	**8,858,216**	**9,186,229**	**9,415,911**	**9,632,145**
NET PATIENT REVENUE				
Medicare Fee for Service	19,549,532	20,274,067	20,780,978	21,258,206
Medicare Managed Care	34,801,274	36,091,147	36,993,531	37,843,076
Medicaid	330,343	342,700	351,268	359,335
Medicaid Managed Care	3,547,265	3,678,761	3,770,741	3,857,335
Commercial	4,281,285	4,439,986	4,550,999	4,655,511
Other	317,676	329,478	337,715	345,471
Self Pay/Charity	(580,062)	(601,464)	(616,502)	(630,660)
TOTAL NET PATIENT REVENUE	**62,247,314**	**64,554,675**	**66,168,730**	**67,688,274**
Other Operating Revenue	722,728	737,182	751,926	766,964
TOTAL NET OPERATING REVENUE	**62,970,041**	**65,291,857**	**66,920,656**	**68,455,238**
OPERATING EXPENSES				
Salary and Wages	38,594,868	39,893,088	40,899,928	41,843,980
Benefits	10,485,454	10,839,902	11,114,169	11,371,117
Supplies	1,231,568	1,276,354	1,308,267	1,338,311
Purchased Services	2,451,415	2,518,466	2,581,435	2,640,717
Other Expenses	2,160,227	2,236,993	2,292,925	2,345,581
TOTAL OPERATING EXPENSES	54,923,532	56,764,804	58,196,723	59,539,706
NON-OPERATING EXPENSES				
Depreciation	1,055	-	-	-
System Allocation	4,407,903	4,570,430	4,684,446	4,791,867
TOTAL NON-OPERATING EXPENSES	4,408,958	4,570,430	4,684,446	4,791,867
TOTAL EXPENSES	59,332,490	61,335,234	62,881,169	64,331,572
NET OPERATING INCOME (LOSS)	3,637,551	3,956,623	4,039,486	4,123,666
NOI %	5.8%	6.1%	6.0%	6.0%

Source: Providence

Providence Home Health Proforma Forecast, 2020 – 2023

With Project

Expense Statement

	2020	2021	2022	2023
	Forecast	Forecast	Forecast	Forecast
Home Visits	**260,198**	**269,842**	**269,842**	**276,589**
SALARIES & BENEFITS				
Registered Nurse (RN)	16,375,991	16,936,423	17,350,769	17,741,663
LPN	762,407	777,655	793,208	809,072
Home Health Aide	643,744	666,774	683,464	699,178
Administrative and Clerical	3,188,466	3,276,185	3,352,951	3,431,008
Physical Therapist (PT)	8,628,314	8,948,372	9,172,199	9,382,584
Occupational Therapist (OT)	3,417,027	3,539,261	3,626,433	3,710,193
Social Worker (MSW)	788,411	813,945	833,181	851,910
Speech Therapist (ST)	1,047,163	1,082,314	1,108,281	1,132,750
Management/Supervisor	3,155,711	3,252,772	3,368,068	3,462,020
Other	121,690	124,123	126,606	129,138
Agency	465,945	475,264	484,769	494,465
Employee Benefits	10,485,454	10,839,902	11,114,169	11,371,117
TOTAL SALARIES & BENEFITS	**49,080,322**	**50,732,990**	**52,014,097**	**53,215,097**
PROFESSIONAL FEES				
Legal and Professional	-	-	-	-
TOTAL PROFESSIONAL FEES	**-**	**-**	**-**	**-**
SUPPLIES				
Medical Supplies	1,194,505	1,238,576	1,269,544	1,298,699
Non Medical Supplies	10,962	10,794	11,064	11,318
Pharmacy Supplies	4,596	5,397	5,532	5,659
Office Supplies	15,126	16,191	16,595	16,976
Other Supplies	6,379	5,397	5,532	5,659
TOTAL SUPPLIES	**1,231,568**	**1,276,354**	**1,308,267**	**1,338,311**
PURCHASED SERVICES				
Management Fees	1,619,456	1,678,420	1,720,385	1,759,893
Print and Publications	108,201	110,635	113,402	116,006
Advertising and Marketing	1,549	837	857	877
Telephone and Wireless	249,916	259,049	265,526	271,623
Translation Services	183,058	188,890	193,612	198,059
Maintenance Services	17,131	18,889	19,361	19,806
Other Purchased Services	272,104	261,747	268,292	274,453
TOTAL PURCHASED SERVICES	**2,451,415**	**2,518,466**	**2,581,435**	**2,640,717**
OTHER EXPENSES				
Mileage	1,283,065	1,330,323	1,363,585	1,394,899
Travel	20,723	21,587	22,127	22,635
Training & Education	30,078	32,381	33,191	33,953
Equipment (PC, Printers, etc.)	126,680	129,524	132,763	135,812
Dues and Memberships	3,246	2,698	2,766	2,829
Lease Expense	667,331	690,796	708,068	724,329
Equipment Lease	9,410	10,794	11,064	11,318
Licensing	11,298	10,794	11,064	11,318
Other Miscellaneous Expenses	8,397	8,095	8,298	8,488
TOTAL OTHER EXPENSES	**2,160,227**	**2,236,993**	**2,292,925**	**2,345,581**
TOTAL OPERATING EXPENSES	54,923,532	56,764,804	58,196,723	59,539,706
NON-OPERATING EXPENSES				
Depreciation	1,055	-	-	-
Allocated System Expense	4,407,903	4,570,430	4,684,446	4,791,867
TOTAL NON-OPERATING EXPENSES	4,408,958	4,570,430	4,684,446	4,791,867
TOTAL EXPENSES	59,332,490	61,335,234	62,881,169	64,331,572

Source: Providence

Providence Home Health Proforma Forecast Assumptions

The Project (Clark County Only Forecast):

- The project is assumed to start as of July 1, 2020 or upon CN approval.
- Given the level of projected unmet need by 2022 in Clark County (140,597 visits), total project utilization is assumed to reach capacity of one agency (10,000) by 2023 with moderate ramp-up assumed in prior years.
- Total need was based on the standard use rate assumed by the Washington State Health Plan:
  - Age Cohort 0-64 – use rate of 0.005
  - Age Cohort 65-79 – use rate of 0.044
  - Age Cohort 80+ – use rate of 0.183
- Utilization forecasts by discipline are then estimated using the following distribution of visits based on existing operations current YTD 2019 levels:
  - Skilled Nursing – 44.4%
  - Physical Therapy – 32.7%
  - Occupational Therapy – 11.8%
  - Home Health Aides—5.4%
  - Speech Therapy—3.1%
  - Social Workers—2.6%

Existing Operations (Without "The Project"):

- Current operations based on Providence Home Health – Portland.
- 2019 Forecast "base" visit volume of 242,640.
- 2020 visit volume based on 6% year-over-year growth rate in-line with current budgeted expectations for total existing volume.
- 2021-2023 visit volume based on 2% annual growth rate.
- Inflation is excluded from the forecast (both with and without the project)

Source: Providence

Revenue and Expense Assumptions (Details)

A	B	C	D
Category/Item	**General Assumptions (Forecasted Years 2020-2023)**	**Assumptions for THE Clark Project (If Different)**	**Additional Notes**
Home Visits	6% growth in 2020 + 2% increased volume per year		
GROSS PATIENT REVENUE (GPR)			
Medicare Fee for Service	Gross Patient Revenue (GPR) per visit by payer type **x** estimated number of visits, based on 2019 YTD actual GPR/visit		
Medicare Managed Care			
Medicaid			
Medicaid Managed Care			
Commercial			
Other			
Self Pay			
TOTAL CONTRACTUAL ALLOWANCES	Revenue Deductions per visit by payer type **x** estimated number of visits, based on 2019 YTD actual Deductions/visit		
Bad Debt	0.35% of total GSR based on 2016-2018 average		
Charity Care	0.54% of GPR based on 2020 budget and historical average		
Other Operating Revenue	$2.81 / visit - based on 2020 forecasted expectation	No assumed additional Other Operating Revenue for Clark	Includes other inter-affiliate transfers for reimbursement of services provided to entities internal to Providence
SALARIES & BENEFITS			
Registered Nurse (RN)	Total FTE count based on average number of FTEs needed to support visit volume; Salaries calculated as FTEs by discipline (based on 2019 YTD mix) x average wage rates by discipline x 2,080 hours (full-time equivalent)		
LPN			
Home Health Aide			
Administrative and Clerical			Includes Admin, Medical Director, and Business & Clerical
Physical Therapist (PT)			
Occupational Therapist (OT)			
Social Worker (MSW)			
Speech Therapist (ST)			
Management/Supervisor			
Other		No assumed additional expense for Clark	
Agency		No assumed additional expense for Clark	
Employee Benefits	27.5% of total employed comp based on 2018 level		
TOTAL SALARIES & BENEFITS			
PROFESSIONAL FEES			
Legal and Professional	No assumed Legal and Professional fees at op. unit		
TOTAL PROFESSIONAL FEES			
SUPPLIES			
Medical Supplies	$4.59 / visit based on historical average	Includes start up costs of $641	
Non Medical Supplies	$0.04 / visit based on historical average		
Pharmacy Supplies	$0.02 / visit based on historical average		
Office Supplies	$0.06 / visit based on historical average	Includes start up costs of $200	
Other Supplies	$0.02 / visit based on historical average		Includes minor housekeeping supplies, food supplies, etc.
PURCHASED SERVICES			
Management Fees	$6.22 / visit based on 2019 annualized actual		
Print and Publications	$0.41 / visit based on 2019 annualized actual	Includes start up costs of $1,125	
Advertising and Marketing	$0.0031 / visit based on 2019 annualized actual	Includes start up costs of $750	
Telephone and Wireless	$0.96 / visit based on 2019 annualized actual		
Translation Services	$0.7 / visit based on 2019 annualized actual		
Maintenance Services	$0.07 / visit based on 2019 annualized actual		
Other Purchased Services	$0.97 / visit based on 2019 annualized actual	Includes Epic set-up and Legal Fees for start up costs of $18,720	Includes utilities and other purchased healthcare services such as records management, security, answering services, internal catering, etc.
TOTAL PURCHASED SERVICES			
OTHER EXPENSES			
Mileage	$4.93 / visit based on 2019 annualized actual		
Travel	$0.08 / visit based on 2019 annualized actual		
Training & Education	$0.12 / visit based on 2019 annualized actual		
Equipment (PC, Printers, etc.)	$0.48 / visit based on 2019 annualized actual	Includes start up costs of $2,000	
Dues and Memberships	$0.01 / visit based on 2019 annualized actual		
Lease Expense	$2.56 / visit based on 2019 annualized actual		
Equipment Lease	$0.04 / visit based on 2019 annualized actual		
Licensing	$0.04 / visit based on 2019 annualized actual	Includes start up costs of $750; on-going $120/Clinician Addition	
Other Miscellaneous Expenses	$0.03 / visit based on 2019 annualized actual		Includes Taxes, postage, and minor recruitment expenses.
NON-OPERATING EXPENSES			
Depreciation	Assets fully depreciated in 2020		
Allocated System Expense	Estimated at 7% of NOR		

A = Expense or revenue line item.

B = General assumptions for AS IS (without project) and for The Project (unless otherwise noted in column C)

C = Additional assumptions that apply to The Project (Clark County) only. For example: agency start-up costs.

D = Additional notes to explain column B assumptions.

Source: Providence

Start-up Cost Assumptions (Clark County Project)

	Start-up Costs	Basis of Assumption
Supplies:		
Medical Supplies	$ 641	Update car stock for clinicians working in Clark County at $148 per RN and Therapists; $86 per Aide; Increase medical supplies in inventory and creams/lotions ($100).
Office Supplies	$ 200	Paper for printer, additional pens/post its for touchdown area, flip charts for planning
Purchased Services:		
Printing and Publications	$ 1,125	Admit Packets ($5 x 150 = $750); 300 Brochures ($1.25 each x 300 = $375)
Advertising and Marketing	$ 750	Update Website (5 hours x $50 - $250); Mailings to physician's offices and facilities ($1.00 x 500 = $500)
Other Expense:		
Equipment (PC, Printers, etc.)	$ 2,000	1 computer in office for touchdown at $1,000 to include all peripherals (screen, keyboard, etc.); Additional printer for growth at $1,000
Licensing (clinicians)	640	New licenses for clinicians to work in Clark County ($120 x 3 = $360); SW licensing $100 x 1 = $100; RN $90 x 2 = $180. All Providence Chaplains are Clinical Pastoral Education certified so do not need a license
Other Miscellaneous Expenses		
- EPIC set up	$ 16,000	1 Epic analyst for a 2.5 weeks ($100 x 40 x 2.5 = $10,000), Contract setup (~8 hrs. * $75 = $600), reports (8 hrs. x $75 = $600), chg of acctg reports (2x 40 x $60 = $4,800)
- Legal/Regulatory	$ 2,720	Updating any contracts with providers. Review of policies for State regulatory requirements. Legal - 8 hours at $250 per hour = $2,000; Compliance 8 hours at $90 per hour = $720

Source Providence

Exhibit 19
Providence Home Health Balance Sheet and Cash Flow Proforma

Providence Home Health Cash Flow Proforma, 2020-2023

	2020	2021	2022	2023
Cash flows from Operating Activities:				
Net Income (Loss) from Operations	3,637,551	3,956,623	4,039,486	4,123,666
Adjustments to Reconcile Net Income to Cash Provided by Operations:				
Depreciation and Amortization	1,055	-	-	-
Change in Accounts Receivable	(510,205)	(280,222)	(196,047)	(184,567)
Change in Accounts Payable & Accrued Expenses	340,023	16,495	71,873	76,531
Change in Accrued Compensation	133,697	6,486	28,261	30,092
Total Adjustments	(35,430)	(257,241)	(95,913)	(77,944)
Net Cash Provided by Operations	**3,602,122**	**3,699,382**	**3,943,574**	**4,045,722**
Cash Flows from Investing Activities:				
Net Cash Provided by Investing Activities				
Cash Flows from Financing Activities:				
Cash (To)/From Affiliates	(3,602,122)	(3,699,382)	(3,943,574)	(4,045,722)
Net Cash Provided by Financing Activities	**(3,602,122)**	**(3,699,382)**	**(3,943,574)**	**(4,045,722)**
Net Increase (Decrease) in Cash	-	-	-	-
Cash Balance at Beginning of Year	-	-	-	-
Cash Balance at End of Year	**-**	**-**	**-**	**-**

Source: Providence

Please note that Providence does not hold cash flow statements at the facility level, and Providence does not routinely use facility level cash flow statements as part of its financial analysis when evaluating new business ventures. With that said, for purposes of this Application and to satisfy the Department's questions relating to cash flow statements, Providence has prepared a cash flow statement. This cash flow statement was solely created for the Department's review of this Application.

Providence Home Health Balance Sheet Proforma, 2020-2023

	2020	2021	2022	2023
ASSETS				
Current Assets:				
Cash and Cash Equivalents	-	-	-	-
Accounts Receivable	*9,954,774*	*10,323,726*	*10,581,850*	*10,824,859*
Less Allowance for Bad Debts	*(745,995)*	*(773,644)*	*(792,988)*	*(811,198)*
Less Allowance for Contractual Adjustments	*(1,648,043)*	*(1,709,124)*	*(1,751,857)*	*(1,792,088)*
Accounts Receivable (Net)	7,560,736	7,840,958	8,037,005	8,221,572
Total Current Assets	**7,560,736**	**7,840,958**	**8,037,005**	**8,221,572**
Property and Equipment:				
Fixed Assets	*816,196*	*816,196*	*816,196*	*816,196*
Less Accumulated Depreciation	*(816,196)*	*(816,196)*	*(816,196)*	*(816,196)*
Total Property and Equipment	**-**	**-**	**-**	**-**
Other Assets	**-**	**-**	**-**	**-**
Total Assets	**7,560,736**	**7,840,958**	**8,037,005**	**8,221,572**
LIABILITIES AND CAPITAL				
Current Liabilities:				
Accounts Payable & Accrued Expenses	3,444,858	3,461,353	3,533,227	3,609,758
Accrued Compensation	1,354,514	1,361,000	1,389,261	1,419,353
Total Current Liabilities	**4,799,372**	**4,822,354**	**4,922,488**	**5,029,111**
Long-Term Liabilities	**-**	**-**	**-**	**-**
Total Liabilities	**4,799,372**	**4,822,354**	**4,922,488**	**5,029,111**
Net Assets	**2,761,363**	**3,018,604**	**3,114,517**	**3,192,461**
Total Liabilities and Net Assets	**7,560,736**	**7,840,958**	**8,037,005**	**8,221,572**

Source: Providence

Please note that Providence does not hold a balance sheet at the facility level, and Providence does not routinely use facility level balance sheets as part of its financial analysis when evaluating new business ventures. With that said, for purposes of this Application and to satisfy the Department's questions relating to a balance sheet, Providence has prepared a balance sheet. This balance sheet was solely created for the Department's review of this Application.

Exhibit 20
Providence Home Health Revenue and Expense Statements

Providence Home Health Actuals, 2016 – 2019
Revenue and Expense Statement

	2016	2017	2018	2019
	Actuals	Actuals	Actuals	Projected
Home Visits	**231,250**	**235,832**	**240,181**	**242,640**
GROSS PATIENT REVENUE (GPR)				
Medicare Fee for Service	19,351,614	18,575,963	19,951,160	19,564,569
Medicare Managed Care	29,947,730	30,099,793	31,972,164	34,256,513
Medicaid	530,924	478,402	534,182	485,437
Medicaid Managed Care	4,602,177	4,632,604	4,666,530	5,828,893
Commercial	5,110,852	5,134,348	5,345,549	5,675,162
Other	152,339	213,185	351,936	441,208
Self Pay	537,982	554,348	140,303	55,488
TOTAL GROSS PATIENT REVENUE	**60,233,618**	**59,688,644**	**62,961,824**	**66,307,270**
DEDUCTIONS FROM REVENUE				
Medicare Fee for Service	485,291	984,515	(190,266)	1,334,255
Medicare Managed Care	4,786,911	4,791,843	2,047,005	1,803,657
Medicaid	264,194	254,995	135,805	177,386
Medicaid Managed Care	1,912,340	1,867,500	1,944,216	2,521,001
Commercial	1,541,726	1,696,473	1,603,715	1,682,782
Other	87,428	176,495	114,695	144,969
Self Pay	39,039	52,652	26,190	6,076
TOTAL CONTRACTUAL ALLOWANCES	**9,116,929**	**9,824,472**	**5,681,358**	**7,670,126**
Bad Debt	62,691	214,332	375,864	(30,763)
Charity Care	217,798	241,165	470,434	358,255
TOTAL DEDUCTIONS FROM REVENUE	**9,397,417**	**10,279,970**	**6,527,656**	**7,997,618**
NET PATIENT REVENUE				
Medicare Fee for Service	18,866,323	17,591,448	20,141,426	18,230,314
Medicare Managed Care	25,160,819	25,307,950	29,925,159	32,452,856
Medicaid	266,730	223,407	398,377	308,051
Medicaid Managed Care	2,689,837	2,765,104	2,722,314	3,307,893
Commercial	3,569,126	3,437,875	3,741,834	3,992,380
Other	64,912	36,690	237,242	296,239
Self Pay/Charity	218,455	46,198	(732,184)	(278,080)
TOTAL NET PATIENT REVENUE	**50,836,201**	**49,408,674**	**56,434,168**	**58,309,652**
Other Operating Revenue	41,125	123,170	518,815	771,233
TOTAL NET OPERATING REVENUE	**50,877,326**	**49,531,844**	**56,952,983**	**59,080,885**
OPERATING EXPENSES				
Salary and Wages	32,302,748	33,586,598	34,885,218	36,403,059
Benefits	8,746,578	9,149,172	9,547,772	9,684,232
Supplies	1,107,140	1,179,306	1,308,747	987,245
Purchased Services	2,093,865	2,227,875	2,218,862	2,266,786
Other Expenses	1,776,987	1,795,921	1,881,197	2,011,991
TOTAL OPERATING EXPENSES	**46,061,264**	**47,971,794**	**49,871,141**	**51,353,313**
NON-OPERATING EXPENSES				
Depreciation	2,951	2,737	2,737	2,737
System Allocation	3,561,413	3,467,229	3,986,709	4,135,662
TOTAL NON-OPERATING EXPENSES	**3,564,363**	**3,469,966**	**3,989,446**	**4,138,399**
TOTAL EXPENSES	**49,625,627**	**51,441,761**	**53,860,587**	**55,491,712**
NET OPERATING INCOME (LOSS)	**1,251,699**	**(1,909,916)**	**3,092,396**	**3,589,173**
NOI %	2.5%	-3.9%	5.4%	6.1%

Source: Providence

Providence Home Health Actuals, 2016 – 2019

Expense Statement

	2016	2017	2018	2019
	Actuals	Actuals	Actuals	Projected
Home Visits	**231,250**	**235,832**	**240,181**	**242,640**
SALARIES & BENEFITS				
Registered Nurse (RN)	15,101,383	14,963,506	15,241,760	15,433,049
LPN	351,147	346,026	554,788	725,563
Home Health Aide	551,760	553,845	582,478	605,574
Administrative and Clerical	2,306,752	2,516,916	2,979,073	3,011,123
Physical Therapist (PT)	6,794,066	7,461,419	7,925,127	8,117,409
Occupational Therapist (OT)	2,780,150	2,965,647	3,122,374	3,217,241
Social Worker (MSW)	490,837	634,331	667,511	743,235
Speech Therapist (ST)	737,715	864,062	930,446	987,422
Management/Supervisor	2,381,303	2,565,351	2,619,827	3,003,209
Other	26,021	101,124	93,132	115,809
Agency	781,614	614,370	168,701	443,428
Employee Benefits	8,746,578	9,149,172	9,547,772	9,684,232
TOTAL SALARIES & BENEFITS	**41,049,326**	**42,735,770**	**44,432,990**	**46,087,291**
SUPPLIES				
Medical Supplies	984,659	1,142,926	1,277,354	953,697
Non Medical Supplies	28,685	11,444	8,210	10,599
Pharmacy Supplies	3,634	3,864	4,075	5,236
Office Supplies	83,628	14,192	12,689	14,335
Other Supplies	6,533	6,880	6,419	3,378
TOTAL SUPPLIES	**1,107,140**	**1,179,306**	**1,308,747**	**987,245**
PURCHASED SERVICES				
Management Fees	1,527,101	1,515,009	1,418,442	1,510,173
Print and Publications	295	73,088	113,077	99,851
Advertising and Marketing	234	879	1,270	745
Telephone and Wireless	240,469	224,060	195,231	233,052
Translation Services	92,906	159,901	188,318	170,705
Maintenance Services	11,109	23,342	8,601	15,975
Other Purchased Services	221,750	231,595	293,923	236,285
TOTAL PURCHASED SERVICES	**2,093,865**	**2,227,875**	**2,218,862**	**2,266,786**
OTHER EXPENSES				
Mileage	1,019,306	1,037,404	1,099,458	1,196,483
Travel	22,931	9,545	16,001	19,324
Training & Education	20,525	24,829	33,988	28,048
Equipment (PC, Printers, etc)	126,123	90,616	98,171	116,266
Dues and Memberships	13,931	4,262	2,020	3,027
Lease Expense	571,627	586,636	611,489	622,299
Equipment Lease	-	5,283	6,967	8,775
Licensing	(1,333)	31,880	7,359	9,939
Other Miscelleneous Expenses	3,877	5,466	5,744	7,830
TOTAL OTHER EXPENSES	**1,776,987**	**1,795,921**	**1,881,197**	**2,011,991**
TOTAL OPERATING EXPENSES	**46,061,264**	**47,971,794**	**49,871,141**	**51,353,313**
NON-OPERATING EXPENSES				
Depreciation	2,951	2,737	2,737	2,737
Allocated System Expense	3,561,413	3,467,229	3,986,709	4,135,662
TOTAL NON-OPERATING EXPENSES	**3,564,363**	**3,469,966**	**3,989,446**	**4,138,399**
TOTAL EXPENSES	**49,625,627**	**51,441,761**	**53,860,587**	**55,491,712**

Source: Providence

Exhibit 21
Providence Home Health Balance Sheet and Cash Flow Statements

Providence Home Health Cash Flow Statements, 2016-2019

	2016	2017	2018	2019
Cash flows from Operating Activities:				
Net Income (Loss) from Operations	1,251,699	(1,909,916)	3,092,396	3,589,173
Adjustments to Reconcile Net Income to Cash Provided by Operations:				
Depreciation and Amortization	2,951	2,737	2,737	2,737
Change in Accounts Receivable	(2,847,048)	298,271	(1,818,601)	601,310
Change in Accounts Payable & Accrued Expenses	850,141	518,023	479,010	102,053
Change in Accrued Compensation	682,447	(64,593)	26,819	40,127
Total Adjustments	(1,311,509)	754,438	(1,310,035)	746,227
Net Cash Provided by Operations	**(59,810)**	**(1,155,478)**	**1,782,361**	**4,335,400**
Cash Flows from Investing Activities:				
Net Cash Provided by Investing Activities	**-**	**-**	**-**	
Cash Flows from Financing Activities:				
Cash (To)/From Affiliates	(294,520)	1,150,903	(1,782,367)	(4,335,400)
Net Cash Provided by Financing Activities	**(294,520)**	**1,150,903**	**(1,782,367)**	**(4,335,400)**
Net Increase (Decrease) in Cash	(354,330)	(4,575)	(7)	-
Cash Balance at Beginning of Year	359,226	4,897	321	-
Cash Balance at End of Year	***4,897***	***321***	***315***	**-**

Source: Providence

Please note that Providence does not hold cash flow statements at the facility level, and Providence does not routinely use facility level cash flow statements as part of its financial analysis when evaluating new business ventures. With that said, for purposes of this Application and to satisfy the Department's questions relating to cash flow statements, Providence has prepared a cash flow statement. This cash flow statement was solely created for the Department's review of this Application.

Providence Home Health Balance Sheet Statements, 2016-2019

	2016	2017	2018	2019
ASSETS				
Current Assets:				
Cash and Cash Equivalents	4,897	321	315	-
Accounts Receivable	*6,934,428*	*7,194,191*	*10,074,727*	*9,283,018*
Less Allowance for Bad Debts	*(665,350)*	*(619,153)*	*(754,985)*	*(695,655)*
Less Allowance for Contractual Adjustments	*(137,568)*	*(741,799)*	*(1,667,901)*	*(1,536,832)*
Accounts Receivable (Net)	6,131,510	5,833,240	7,651,841	7,050,531
Total Current Assets	**6,136,407**	**5,833,561**	**7,652,155**	**7,050,531**
Property and Equipment:				
Fixed Assets	*816,196*	*816,196*	*816,196*	*816,196*
Less Accumulated Depreciation	*(805,402)*	*(808,903)*	*(812,403)*	*(815,141)*
Total Property and Equipment	**10,793**	**7,293**	**3,792**	**1,055**
Other Assets	-	-	-	-
Total Assets	**6,147,200**	**5,840,854**	**7,655,948**	**7,051,586**
LIABILITIES AND CAPITAL				
Current Liabilities:				
Accounts Payable & Accrued Expenses	2,005,749	2,523,772	3,002,782	3,104,835
Accrued Compensation	1,218,465	1,153,872	1,180,691	1,220,818
Total Current Liabilities	**3,224,213**	**3,677,643**	**4,183,472**	**4,325,652**
Long-Term Liabilities	-	-	-	-
Total Liabilities	**3,224,213**	**3,677,643**	**4,183,472**	**4,325,652**
Net Assets	**2,922,987**	**2,163,210**	**3,472,475**	**2,725,934**
Total Liabilities and Net Assets	**6,147,200**	**5,840,854**	**7,655,948**	**7,051,586**

Source: Providence

Please note that Providence does not hold a balance sheet at the facility level, and Providence does not routinely use facility level balance sheets as part of its financial analysis when evaluating new business ventures. With that said, for purposes of this Application and to satisfy the Department's questions relating to a balance sheet, Providence has prepared a balance sheet. This balance sheet was solely created for the Department's review of this Application.

Exhibit 22
Providence St. Joseph Health Audited Financials, 2016-2018

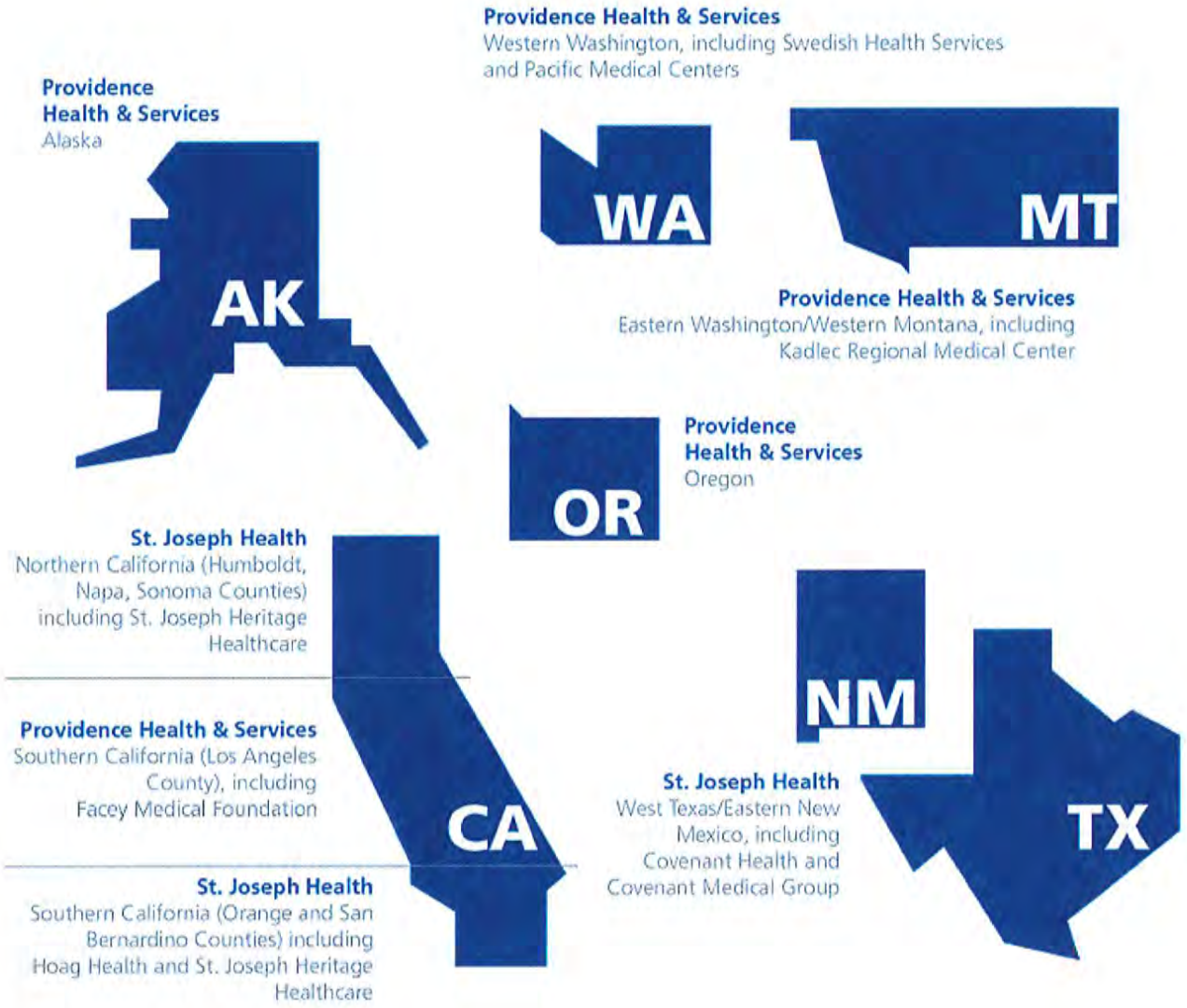
Providence St. Joseph Health

Management's Discussion and Analysis of Financial Condition and Results of Operations

Year ended December 31, 2016

About Providence St. Joseph Health

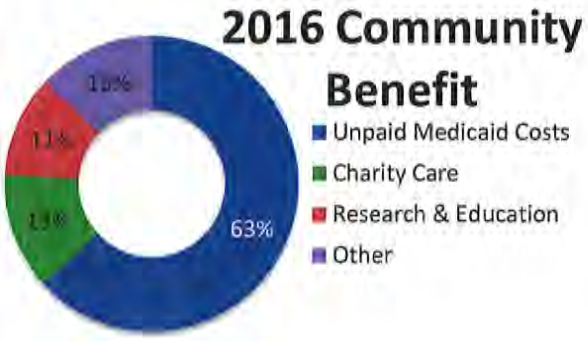
Effective July 1, 2016, Providence Health & Services and St. Joseph Health came together to serve more people in a partnership that joins two remarkable organizations with rich heritages. We are now connected by a new parent organization, Providence St. Joseph Health. Together, over 100,000 of our caregivers (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

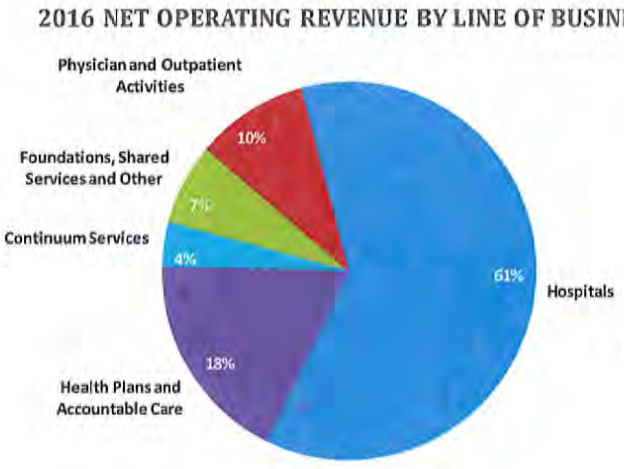
Key Volume Indicators	Providence St. Joseph Health (Pro Forma)			
DATA PRESENTED YEAR TO DATE; IN THOUSANDS UNLESS NOTED	2016 ACTUAL	2015 ACTUAL	YTD VAR	YTD VAR %
Inpatient Admissions	526	519	7	1%
Acute Adjusted Admissions	989	957	32	3%
Outpatient Visits	24,352	22,875	1,477	6%
Total Surgeries	567	545	22	4%
Providence Health Plan Members	639	513	126	25%

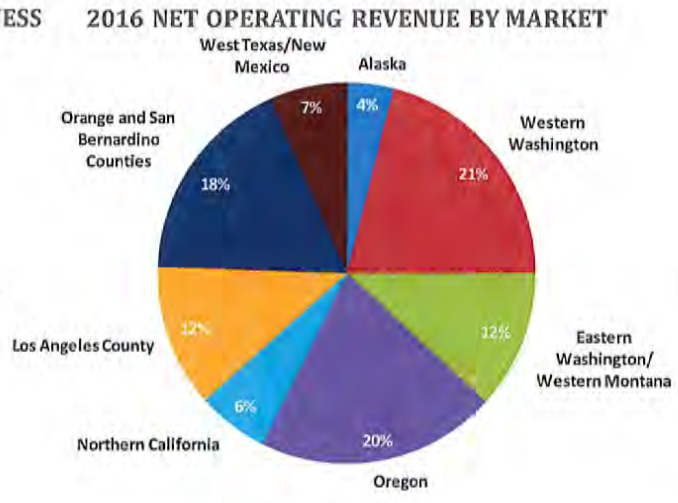
While the System has experienced volumes growth in 2016, trends in this growth have been highly influenced by the effects of the Affordable Care Act. Specifically, growth has been highest amongst Medicaid patients with an overall higher acuity level, which require additional resources to serve. Additionally, 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

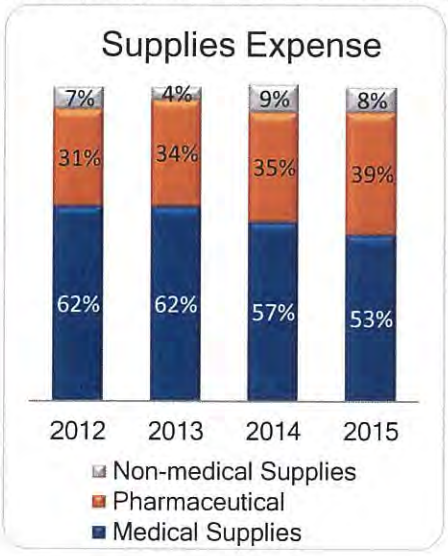
Key Efficiency Indicators *Data is year-to-date*	2015	2014	Organic Growth*
FTEs (presented in thousands)	70.4	65.4	67.1
Productivity - Labor % Net Service Rev.	50.8%	52.0%	50.9%
Supplies % Net Service Revenue	17.6%	17.7%	17.5%
Efficiency - Expense/CMAA	$ 12,040	$ 11,270	$ 12,070

** 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

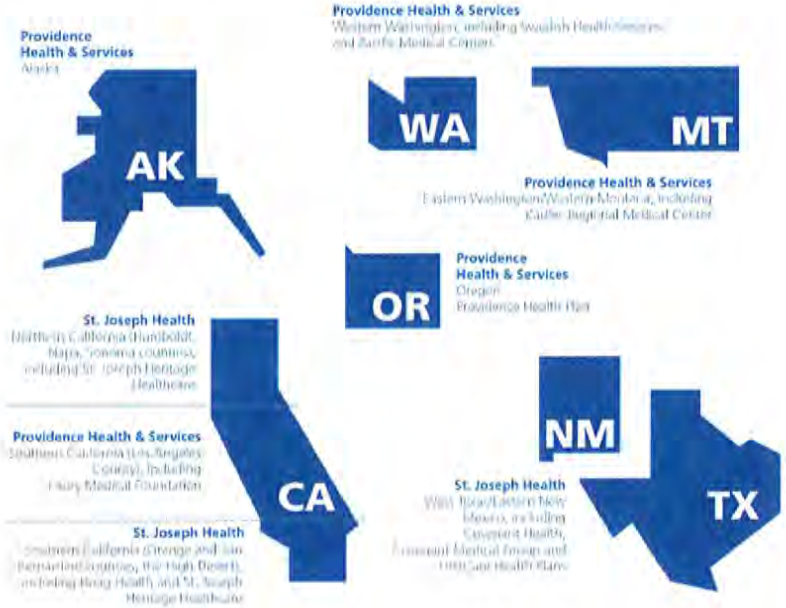
Our Organization

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

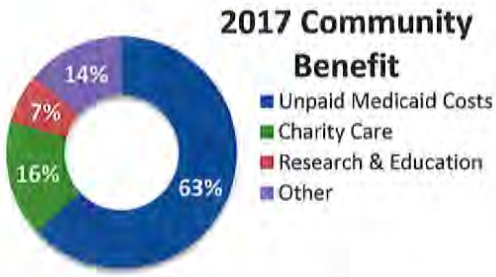
SWEDISH EXPRESS CARE VIRTUAL | PROVIDENCE Express Care at Walgreens | PROVIDENCE Express Care at Home | circle | xealth

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.

Providence St. Joseph Health

CONTINUING DISCLOSURE ANNUAL REPORT
(Filed pursuant to Rule 15c2-12(b)(5))

PROVIDENCE ST. JOSEPH HEALTH
AND THE OBLIGATED GROUP

Name, Address and Telephone Number of Obligor:

Providence St. Joseph Health
1801 Lind Ave SW
Renton, WA 98057
Attention: Venkat Bhamidipati,
Executive Vice President and Chief Financial Officer

Title of Bonds to Which Report Relates:

See **Exhibit 5** attached hereto

Fiscal Year to Which Report Relates:

Fiscal Year ended December 31, 2018

Including Management's Discussion and Analysis and Results of Operations

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About Providence St. Joseph Health

Our organization

Providence St. Joseph Health (the "System") has been a strong and stable force for more than 160 years. As one of the largest health systems in the United States, our Mission calls us to serve the most vulnerable and poor members of our community with dignity and respect, reflecting the legacy of the Sisters of St. Joseph and the Sisters of Providence. The sisters incorporated their works of charity in 1859, creating the structure for the current network of health care services.

Our Excellence Recognized in 2018

- Ranked 9 of 250 on the Forbes list of Best Employers for New Graduates
- 21 of the System's 51 hospitals were included in U.S. News and World Report's annual rankings of Best Hospitals
- Ranked 8 of 20 on the Forbes list of Best Employers for Women

Our vision, Health for a Better World, is driven by a fundamental belief that health is a human right. We strive to increase access to health care and our dedicated caregivers provide quality, compassionate care to all those we serve, regardless of coverage or ability to pay. In the transforming health care landscape, our advocacy and engagement reflects our deep commitment to preserve safety net programs, such as Medicaid, and working with like-minded partners and lawmakers on policies that have a meaningful impact on the health and well-being of those we serve. We are privileged to serve in vibrant markets in the western United States with growing populations, which has led to consistent increases in service utilization in these markets. 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 supportive housing, financial assistance programs, and educational ministries that include a high school and university.

The Continuing Disclosure Annual Report (the "Annual Report") is intended solely to provide certain limited financial and operating data in accordance with undertakings of the System and the Members of the Obligated Group under Rule 15c2-12 (the "Undertaking") and does not constitute a reissuance of any Official Statement relating to the bonds described above or a supplement or amendment to such Official Statement. The Annual Report contains certain financial and operating data for the fiscal year ended December 31, 2018. The System has undertaken no responsibility to update such data since December 31, 2018, except as set forth herein. This Annual Report may be affected by actions taken or omitted or events occurring after the date hereof. The System has not undertaken to determine, or to inform any person, whether any such actions are taken or omitted or events do occur. The System disclaims any obligation to update this Annual Report or to file any reports or other information with repositories or any other person except as specifically required by the Undertaking.

The System, headquartered in Renton, Washington, is governed by a sponsorship council made up of members of its two sponsoring ministries, Providence Ministries and St. Joseph Health Ministry. The System operates hundreds of programs and services across seven states. We are a diverse family of organizations striving to create health for a better world, one community at a time, while ensuring the continued vibrancy of not-for-profit, Catholic health care in the United States. Together, we are bringing quality care and services to all, with a special emphasis on those most in need.

The Mission
As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable ®

Our Values
Compassion | Dignity | Justice | Excellence | Integrity

Our Vision
Health for a Better World

Our Promise
"Know me, care for me, ease my way."

Our Strategic Plan

Innovating new approaches to strengthen the Mission and continuously improve. Guided by the Mission and our values, we are executing a strategic plan that will accelerate our progress toward achieving our vision of Health for a Better World. This far-reaching vision includes continuing to deliver high-quality, patient-centered care; ensuring patients are digitally enabled through appropriate technology; and our ministries serve as a partner in health for the patients and communities we serve. We intend to achieve this by focusing on the core areas of revenue growth, capital efficiency and modernization. Our 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 quality health care
- Stewarding our resources to improve operational earnings
- Fostering community commitment to our Mission via philanthropy
- Creating a work experience where caregivers are developed, fulfilled and inspired to carry on the Mission
- Being the provider of choice in all our communities

Be our communities' health partner. We will be our communities' health partner, working to achieve the physical, spiritual and emotional well-being of all. We seek to ease the way of our communities by:

- Transforming care and improving population health outcomes, especially for those who are 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 our communities, and 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:

- Diversifying sources of earnings to ensure sustainability of the ministry
- Digitally enabling, simplifying, and personalizing the health experience
- Creating an integrated scientific wellness, clinical research and genomics program that is nationally recognized for breakthrough advances
- Utilizing insights and value from big data to drive strategic transformation
- Activating the voice and presence of the System nationally to improve health policies

Strategic affiliations. As part of our overall strategic planning and development process, the System regularly evaluates and, if deemed beneficial, selectively pursues opportunities to affiliate with other service providers and invest in new facilities, programs, or other health care related entities. Likewise, we are frequently presented with opportunities from, and conduct discussions with, third parties regarding potential affiliations, partnerships, mergers or acquisitions, including some that could affect the Obligated Group Members. System management pursues such arrangements when there is a perceived strategic or operational benefit that is expected to enhance our ability to achieve the Mission and/or deliver on our strategic objectives. As a result, it is possible that the current organization and assets of the Obligated Group may change. At this time, all such discussions are preliminary in nature and do not necessarily indicate an intention to expand or contract the System, through partnership, affiliation, merger or acquisition, or to add or withdraw Members of the Obligated Group.

Industry Trends

The formation of new coalitions will make 2019 an inflection point in health care. We anticipate many diverse organizations will come together to collaborate on key issues. We expect to see changes that measurably improve health, affordability and transparency. We are tracking the following developments ahead:

- **Diverse coalitions** will form to address challenges in health care. In 2018, we were one of seven health systems that banded together to launch Civica Rx, a not-for-profit generic drug company formed to address the crisis of rising generic pharmaceutical costs and drug shortages. We expect more non-traditional coalitions with providers asserting stronger leadership in areas such as big data, digital innovation and advocacy.
- **Tech industry talent** will continue to join health care to help develop innovative solutions that will improve health and the delivery of care. We have been a leader in recruiting talent from outside the industry, including the recent hiring of our new chief information officer.
- **Data security** will be a primary concern as cloud computing improves how providers aggregate and leverage data to support more informed clinical decision making and enable predictive analytics. As providers build partnerships with tech firms to address these issues, providers will serve as leading advocates for ensuring patient data is secure and confidential.
- **Improving quality and reducing costs in the Medicaid program** will be a key focus. Medicaid is a critical program and vital safety net for one in five Americans. Providers will continue to be a strong voice for preserving Medicaid expansion and make it a strategic priority to improve the health of Medicaid populations, especially those with complex health conditions.

Leadership in the Health Care Industry

We announced the selection of **B.J. Moore**, formerly of Microsoft, as Chief Information Officer in 2018 overseeing information services and partnering with other leading organizations in areas such as cloud computing and artificial intelligence.

Key Initiatives

Implementing improvement initiatives to respond to the changes in the industry. We are driving modernization and functional excellence by reimagining our structures, processes and practices, streamlining and improving access to tools and resources for our caregivers, and leverage our size to improve productivity.

Driving innovation through unconventional partnerships and new coalitions. We are investing to reinvent how we engage with our patients and deliver the best quality, highest-value health care to those we serve. For example, in order to increase access to care and offer a seamless patient experience, we formed a partnership with One Medical. This partnership provides complementary services through our Express Care platform, medical groups and ancillary services.

"We're excited to build upon our existing partnerships, as well as establish new ones that can help us advance our vision of Health for a Better World."
-Rod Hochman, M.D., President and CEO

Making profound breakthroughs in human health through systems biology. We are harnessing the potential of genomic, proteomic and biometric data to help patients improve their health. We are pioneering predictive modeling through our research affiliate, the Institute for Systems Biology (ISB), a biomedical research organization composed of a cross-disciplinary team of scientists with expertise in biology, technology, computer science, engineering, and bioinformatics. We are currently one of the leading health system practicing systems-driven medicine positioning us as a national and global leader among those inventing the future of healthcare. With 170 full-time scientists, researchers, and other talented staff from 30 countries, ISB has produced over 1,600 research publications since 2000, incubated over 19 spinout companies, and has generated over $445 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 both nationally and eventually globally.

Policy and advocacy

Advocating to improve individual and population health. We have made strides advocating on behalf of the millions of patients and customers we serve each year. In every state we serve, and at the national level, our system was a robust voice for preserving Medicaid coverage and the Affordable Care Act, which made possible the expansion of Medicaid. Our advocacy enabled expansion of telestroke - a key part of our telehealth strategy to reduce cost, and increased access and flexibility for patients. We were steadfast in advocating for accessible, affordable prescription drugs, including the 340B Drug Pricing Program, and essential generic medications. In 2018, we strongly advocated for the Veteran Affairs MISSION Act as it advanced through Congress and ultimately was passed into law. The legislation will allow us to better care for our veterans. We also advocated for the ACE Kids Act passed by the House of Representatives, which would improve care for children covered by Medicaid who have complex medical conditions, and is now with the Senate for consideration.

> *"We want to show people how Medicaid is a lifeline. And in most cases, it's a temporary lifeline for people to get back on their feet again"*
> ***-Ali Santore, Group Vice President of Government and Public Affairs***

We expect to see and respond to national policy trends toward narrowing coverage, reducing increasing medication costs, promoting a rapid transition to value-based care, and expanding health care price transparency. The Medicaid program is likely to add more maternal health services and pursue innovation with social determinants of health, while giving states further flexibility in Medicaid waivers. Medicare will also look at ways to enable housing and continue to find ways to reduce the administrative burden for providers. Across our states, Medicaid coverage and funding will be a leading topic for legislatures considering a host of budgetary priorities.

PSJH Enterprises

Using technology to improve patient engagement, caregiver productivity and reduce non-value added variation. We work to bring health care into the digital and consumer age through a persistent focus on patient and consumer value. We utilize digital tools to meet and engage patients where they live, deliver care on their terms, and establish a long-term dialogue about their health outside the wall of the exam room. We believe this strategy will lower the cost of care, generate new digital revenue streams, and unlock population health management capabilities and risk arrangements that help entire communities stay healthy.

SWEDISH EXPRESS CARE | VIRTUAL · PROVIDENCE Express Care at Walgreens · PROVIDENCE Express Care at Home · circle · xealth

Funding the future of health care through technology innovations. We founded Providence Ventures in 2014 to manage a $150 million venture capital fund designed to achieve venture class returns through direct investments in innovative health care companies that improve quality and convenience, lower cost and improve health outcomes. We offer investment capital, combined with health system expertise, to companies addressing existing and emerging pain points in health care. We partner with our portfolio companies to refine existing solutions, while expanding their adoption within and beyond our health system. In 2018, we launched a second $150 million fund, Providence Ventures II, to target early and growth-stage health care companies that specialize in health care information technology, technology-enabled services, medical devices, and health care services.

binaryfountain · INDEMAND · omada · Trilliant

Driving transformational change with big data, blockchain, artificial intelligence and machine learning. Digital transformation will be increasingly important to empower patients to become more involved in their care as providers invest in cloud computing, artificial intelligence (AI) and machine learning, and consumer engagement platforms in health care. Population-based analytics are also providing opportunities to further evaluate and optimize care, and methods of health care delivery. We pass the benefits of our highly accessible, data-rich resources to our patients by identifying practices associated with lower costs and better outcomes. We have created a variety of systems built on AI and machine learning using our clinical data to transform care delivery for those we serve. Kyruus, a robust provider search and scheduling solution leverages our AI capabilities and empowers our consumers to find the right providers for their needs. We are also building a next-generation revenue cycle management platform using blockchain technology to transform how payers and providers share information and transact across the revenue cycle.

"New technologies like blockchain, artificial intelligence, and machine learning give us an opportunity to view the complexities of today's health systems through a different lens."
-Venkat Bhamidipati, EVP and CFO

As we utilize our vast data resources to drive operational efficiency, we are optimizing our core electronic health records platform by aligning instances across ministries, representing our dedication to enhancing the patient experience across the continuum of care. We expect cost savings as standardization continues across all ministries, and partners, and anticipate these improvements will also allow our caregivers to serve our patients more efficiently. Our investment in a fully integrated patient system is consistent with our organizational growth strategy to utilize technology to operate more effectively across regions and provide a predictable, reliable experience for patients and caregivers, leading to consistent, high-quality care for those we serve.

Population Health Management

Making a transformational shift from health care to health. Our Population Health Management division is composed of a family of services, including Population Health Informatics, Payer & Provider Contracting, Value-Based Care, Care Management, Pacific Medical Centers and US Family Health Plan, Providence Health Plans and Ayin Health Solutions.

Population Health models and initiatives form a vital pillar in achieving our strategic plan of transforming care, delivering value based care, and 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 and services. We integrate solutions to improve social determinants of health and provide care management for complex patients. We are building community partnerships to increase access to health services, transportation, housing, education, food banks, and mental health services.

Providence Health Plan (PHP) is a 501(c)(4) Oregon non-profit health care service contractor and Providence Health Assurance (PHA), a wholly-owned subsidiary of PHP are collectively referred to as the "Health Plans". Providence Plan Partners (PPP), is a 501(c)(4) Washington non-profit corporation. These three combined entities generated total revenues exceeding two billion and services to over one million lives in 2018.

Providence Health Plan provides services to a wide range of clients, including self-funded employers, and insurance coverage for large group employers, small group employers, individual and family coverage under the Affordable Care Act, Medicare Commercial, Medicare Advantage, Managed Medicaid risk administration, pharmacy benefits management, workers compensation services, and network access services under Providence Preferred plans.

Forming a new population health management company. We formed Ayin Health Solutions, a for-profit Delaware corporation, wholly-owned by PPP. Our new enterprise population heath management company will provide strategic consulting, administrative support and care coordination services for provider sponsored health plans, provider organizations, employers and state agencies with a strong focus on organizations serving Medicaid and Medicare patients. Ayin will serve as the population health engine to support the System's regional ministries and provide an avenue for revenue diversification through a for-profit, non-risk bearing entity. This strategy will improve the health outcomes in more of our communities and diversify our revenue streams.

"Population Health Management provides great opportunities to improve health outcomes, demonstrate value, and better manage health resources and costs. Through Ayin Health, this also presents an expanding area for revenue diversification and business growth"
-Rhonda Medows, M.D., President of Population Health Management and CEO of Ayin Solutions

Covenant Heath System (CHS) held a 67 percent beneficial membership interest in SHA, L.L.C., doing business as FirstCare Health Plans, a health maintenance organization operating in West/Central Texas. The remaining 33 percent of the membership interest was owned by Hendrick Medical Center ("Hendrick"), an unaffiliated not-for-profit corporation located in Abilene, Texas. In October 2018, CHS and Hendrick signed a definitive agreement with Scott and White Health Plan (SWHP) (part of Baylor Scott & White Health) pursuant to which SWHP would acquire FirstCare Health Plans. The transaction with SWHP closed on December 31, 2018, with CHS divesting all of its interest in FirstCare Health Plans as of that date.

Ambulatory Care Network

Providing an optimized and connected ambulatory experience for those we serve. We are focused on providing patients access to an optimized, lower cost, consumer-centric, connected ambulatory care network. We are currently providing over two million visits in our almost 200 sites across seven states, with a roadmap through 2022 to grow the network to serve five million visits in more than 500 sites. We are evolving our care delivery model with more than two million people served in an ambulatory network comprised of 44 ambulatory surgery centers, 51 imaging centers, 71 urgent care centers, and 43 retail clinics. We believe ambulatory networks offer advantages to patients and physicians, including greater affordability, predictability, flexibility, and convenience, while offering a seamless connection to our full continuum of care. This consumer-friendly approach is a key strategy to ensure we are the preferred health partner in the communities we serve. We are expanding our ambulatory care network throughout 2019 in strategic partnerships to improve access and reduce costs for consumers and employers, including increased same-day access through our retail and urgent care clinics. Our strategy is central to our vision of Health for a Better World, which focuses on how we deliver care in the right settings, and our efforts to sustain our Mission for the long term. We have made solid progress toward our commitment to being a partner in health.

Home & Community Care

Building out the continuum of care. As a trusted partner for individuals and families, our community-based care and services are geared to help in times of need, aging and illness, and at the end of life. We provide a full range of post-acute service, including assisted living, skilled nursing and rehabilitation, home health, home infusion and pharmacy services, home medical equipment, hospice and palliative care, Program of All-Inclusive Care for the Elderly (PACE) locations, supportive housing, and personal home care services. As our Mission calls us to serve the most vulnerable and poor members of our community, we provide a full range of services and support more to than 30,000 patients each day. We are experiencing strong growth in these services, creating opportunities for continued growth, innovation and investment.

Physician Enterprises

The System's physician enterprise consists of employed and foundation physicians, providers and their supporting care teams, including employed medical group providers, as well as hospital-based employed physicians. Our Employed Provider Network (the "Provider Network"), which is composed of eight provider service organizations, includes over 7,600 employed providers.

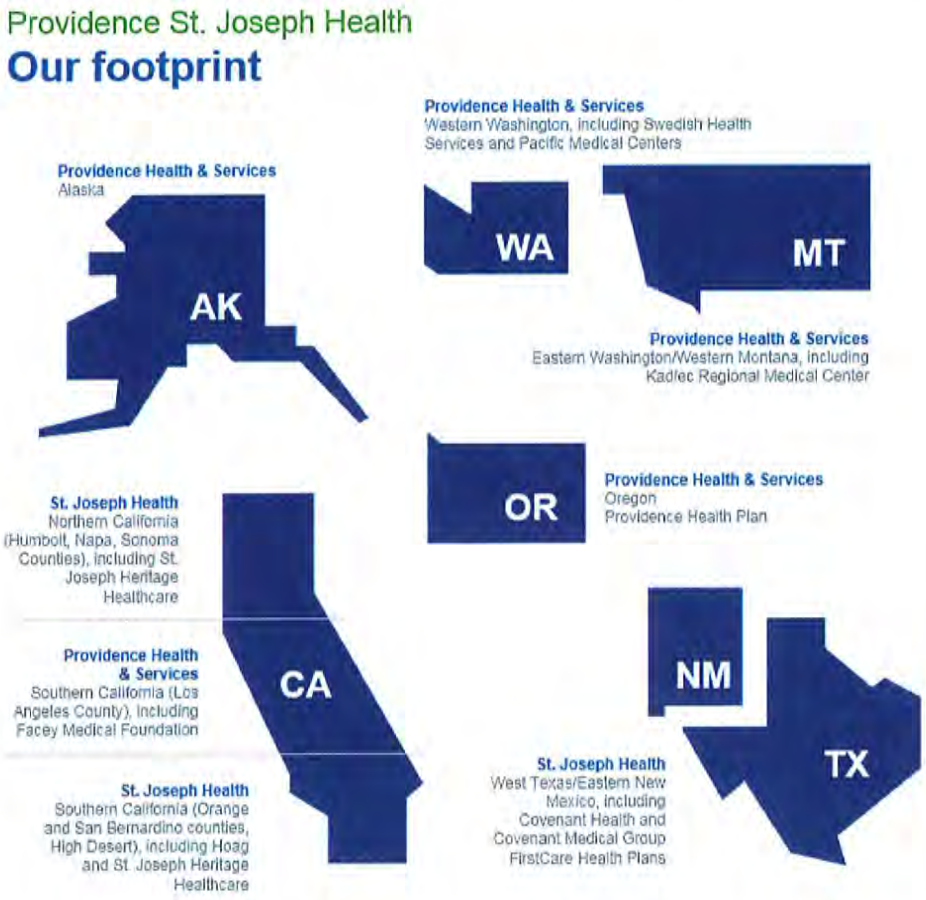
Medical groups and medical foundations within the Provider Network include: Providence Medical Group, a network serving Alaska, Washington and Montana, and Oregon; Swedish Medical Group, with

staffed clinics throughout Washington's greater Puget Sound area; Providence Medical Institute (PMI), in Southern California; Pacific Medical Centers, in western Washington; Kadlec Regional Medical Center (Kadlec), serving communities in southeast Washington; Providence St. John's Medical Foundation, in Southern California; Facey Medical Foundation (Facey), in Southern California; St. Joseph Heritage Healthcare, in Northern and Southern California; and Covenant Medical Group operating in West Texas and Eastern New Mexico. Supplementing our Provider Network are more than 24,000 affiliated providers throughout the System.

Health Care Facilities

We currently own, manage or operate hospitals, surgery centers, urgent care facilities, imaging centers, physician practices, pharmacies, home health services, rehabilitation facilities, a university and a high school, and various other facilities. We have contracted the servicing of certain facilities to allow us to continue our focus on areas that are central to serving our communities, while improving the quality of property management. Our facilities spans seven states across the western United States and include 51 acute care hospitals, 23 long-term care facilities, more than 973 clinics, and 16 supportive housing facilities. The System is organized into the geographic regions shown in the graphic below in Exhibit 1.1.

Exhibit 1.1



Region information

The System's operating revenue share by geographic region is presented for the years ended December 31:

EXHIBIT 1.2 - REGIONAL OPERATING REVENUE SHARE	2018	2017
Alaska	4%	4%
Swedish	11%	11%
Washington and Montana	20%	20%
Oregon	21%	21%
Northern California	6%	6%
Southern California	29%	29%
West Texas and Eastern New Mexico	6%	6%
Other	3%	3%

Alaska

As the largest health system in Alaska, the System operates 17 facilities throughout the state, with a 35 percent inpatient market share statewide in 2017. Providence Alaska Medical Center (PAMC) is the largest hospital in the state. The System's 17 Alaska facilities are located in the greater Anchorage area, with 60 percent inpatient market share. PAMC is a 401-bed acute care facility and the only comprehensive tertiary referral center in the state. St. Elias Specialty Hospital, a 59-bed long term acute hospital (the only one in the state) is also located in the Anchorage area. Three critical access hospitals are located in the remote communities of Kodiak, Seward and Valdez, all co-located with skilled nursing facilities.

Swedish

In the greater Puget Sound area of Washington, Swedish operates five hospital campuses: First Hill and Cherry Hill (in Seattle), Ballard, Edmonds and Issaquah located in King and Snohomish counties. The inpatient market share for Swedish was 27 percent in 2017. Swedish also has ambulatory care centers in Redmond and Mill Creek, and a network of more than 100 primary care and specialty clinics throughout the metropolitan corridor.

Washington and Montana

In the Washington-Montana region, the System operates 12 hospitals, with a 44 percent inpatient market share in 2017. The region is composed of five geographic markets: Northwest Washington, Southwest Washington, Eastern Washington, Southeast Washington and Western Montana, with Medical groups in the region employing over 2,000 providers. The region provides a variety of services, including home health care, primary and immediate care services, inpatient rehabilitation, and general acute care services.

Oregon

The Oregon region operates eight hospitals in Portland, Hood River, Medford, Milwaukie, Newberg, Seaside and Oregon City, with a total inpatient market share of 30 percent in 2017. Providence St. Vincent Medical Center provides tertiary care to the Portland metropolitan market. The region also provides more than 100 primary care, specialty and immediate care clinics, home health care, and housing. The Health Plans are based in Oregon, and a majority of its members (over 600,000) live in the region.

Northern California

The System's ministries in Northern California serve the North Coast, Humbolt, Napa and Sonoma communities with five hospitals, ambulatory surgery centers, urgent care centers, wellness centers, physician offices, home health, hospice, and rehab sites. The acute care hospitals in Northern California had 36 percent inpatient market share in 2017. St. Joseph Heritage Healthcare, a medical foundation, operates clinics in the region with its contracted the physician partners.

Southern California

The Southern California region includes 13 acute care hospitals in Los Angeles, Orange and San Bernardino counties, with a total inpatient market share of 24 percent in 2017. In Los Angeles County, the System operates six acute care facilities. Our largest hospital, Providence St. Joseph Medical Center, is located in Burbank. The System also operates hospitals in Mission Hills, San Pedro, Tarzana, Torrance and Santa Monica. Providence Medical Foundation (PMF) operates 63 practice locations in the market, offering more than 20 types of specialty care. PMF includes the Facey, PMI and Providence St. John's medical foundations, In addition, the System operates seven acute care facilities within Orange and San Bernardino counties: Apple Valley, Fullerton, Mission Viejo, Laguna Beach, Newport Beach, Irvine and Orange. Mission Hospital is located on two campuses in Mission Viejo and Laguna Beach and maintains the region's level II trauma center, as well as a women's center. Hoag Hospital, which is also composed of two campuses, in Newport Beach and Irvine, also includes Hoag Orthopedic Institute, part of St. Joseph Hoag Health alliance. St. Joseph Heritage Healthcare, a medical foundation, operates clinics in the region with its contracted the physician partners.

West Texas and Eastern New Mexico

The West Texas-Eastern New Mexico region includes Covenant Health System and Covenant Medical Group. Covenant is the market's largest health system with seven licensed hospitals; the inpatient market share was 38 percent in 2017. The System also operates Grace Heath System which includes Grace Clinic and Grace Medical Center, Covenant Medical Group, a medical foundation physician network of employed and aligned physicians. Covenant Health Partners, a physician-hospital cooperative organization based in Lubbock, Texas, operates two acute care community hospitals in the region: Covenant Health Plainview and Covenant Health Levelland. Finally, Covenant also operates: Specialty Hospital, a long-term acute care facility; manages a joint ventured acute rehabilitation facility; and operates Hospice of Lubbock.

Obligated group

The System and the entities listed in the following table (collectively, the "Obligated Group") are currently members of the Obligated Group under the Master Trust Indenture (Amended and Restated), dated as of May 1, 2003 (as supplemented and amended, the "Master Indenture") as shown in Exhibit 2.1 below.

Exhibit 2.1 - List of Obligated Group Members

Obligated Group Member	Incorporation	Reference
Providence St. Joseph Health	Washington nonprofit	*"System"*
Providence Health & Services	Washington nonprofit	*"PH&S"*
Providence Health & Services - Washington	Washington nonprofit	*"Providence - Washington"*
Providence Health System - Southern California	California nonprofit religious	*"Providence - Southern California"*
Little Company of Mary Ancillary Services Corporation	California nonprofit public benefit	*"LCMASC"*
Providence Saint John's Health Center	California nonprofit religious	*"Providence - Saint John's"*
Providence St. Joseph Medical Center	Montana nonprofit	*"Providence - SJMC Montana"*
Providence Health & Services - Montana	Montana nonprofit	*"Providence - Montana"*
Providence Health & Services - Oregon	Oregon nonprofit	*"Providence - Oregon"*
Providence Health & Services - Western Washington	Washington nonprofit	*"Providence - Western Washington"*
Swedish Health Services	Washington nonprofit	*"Swedish"*
Swedish Edmonds	Washington nonprofit	*"Swedish Edmonds"*
PacMed Clinics	Washington nonprofit	*"PacMed"*
Western HealthConnect	Washington nonprofit	*"Western HealthConnect"*
Kadlec Regional Medical Center	Washington nonprofit	*"Kadlec"*
St. Joseph Health System	California nonprofit public benefit	*"SJHS"*
St. Joseph Hospital of Orange	California nonprofit public benefit	"St. *Joseph Orange*"
St. Jude Hospital, Inc. [1]	California nonprofit public benefit	*"St. Jude"*
Mission Hospital Regional Medical Center	California nonprofit public benefit	*"Mission Hospital"*
St. Mary Medical Center	California nonprofit public benefit	*"St. Mary"*
Hoag Memorial Hospital Presbyterian	California nonprofit public benefit	*"Hoag Hospital"*
St. Joseph Health Northern California, LLC.	California limited liability company	*"SJHNC"*
Queen of the Valley Medical Center	California nonprofit public benefit	*"Queen of the Valley"*
Santa Rosa Memorial Hospital	California nonprofit public benefit	*"Santa Rosa Memorial"*

St. Joseph Hospital of Eureka	California nonprofit public benefit	*"St. Joseph Eureka"*
Redwood Memorial Hospital of Fortuna	California nonprofit public benefit	*"Redwood Memorial"*
Covenant Health System	Texas nonprofit	*"CHS"*
Covenant Medical Center	Texas nonprofit	*"CMC"*
Methodist Children's Hospital [2]	Texas nonprofit	*"Covenant Children's"*
Methodist Hospital Levelland [3]	Texas nonprofit	*"Covenant Levelland"*
Methodist Hospital Plainview [4]	Texas nonprofit	*"Covenant Plainview"*

[1] Doing business as St. Jude Medical Center
[2] Doing business as Covenant Children's Hospital
[3] Doing business as Covenant Hospital Levelland
[4] Doing business as Covenant Hospital Plainview

The System is the Obligated Group Agent under the Master Indenture. Under the Master Indenture, debt incurred or secured through the issuance of Obligations under the Master Indenture are the responsibility, jointly and severally, of the Obligated Group Members. Pursuant to the Master Indenture, Obligated Group Members may be added to and withdrawn from the Obligated Group under certain conditions described in the Master Indenture. INDEBTEDNESS EVIDENCED OR SECURED BY OBLIGATIONS ISSUED UNDER THE MASTER INDENTURE IS SOLELY THE OBLIGATION OF THE OBLIGATED GROUP, AND SUCH OBLIGATIONS ARE NOT GUARANTEED BY, OR THE LIABILITIES OF, SISTERS OF PROVIDENCE, MOTHER JOSEPH PROVINCE, ANY OTHER PROVINCE OF THE SISTERS OF PROVIDENCE MONTREAL CONGREGATION, THE LITTLE COMPANY OF MARY SISTERS, AMERICAN PROVINCE, SISTERS OF ST. JOSEPH OF ORANGE, THE ROMAN CATHOLIC CHURCH, OR ANY AFFILIATE OF THE SYSTEM THAT IS NOT AN OBLIGATED GROUP MEMBER.

Outstanding Master Trust Indenture Obligations

As of December 31, 2018, the System has 46 Obligations outstanding under the Master Trust Indenture totaling $6,131,000,000. This excludes obligations that secure interest rate or other swap transactions, bank liquidity or credit facilities, and capital leases. The obligations outstanding under the Master Trust Indenture relating to tax-exempt and taxable bond/note indebtedness are described further in the Notes to the Combined Audited Financial Statements for the twelve-month period ended December 31, 2018.

For the year ended December 31, 2018, the audited combined net operating revenue and total assets attributable to the Obligated Group Members were approximately 82 percent and 87 percent, respectively, of the System totals. For the year ended December 31, 2017, the audited combined net operating revenues and total assets attributable to the Obligated Group Members were approximately 83 percent and 88 percent, respectively, of the Systems totals. Refer to Exhibit 7 for voluntary supplemental information on the Obligated Group Members.

Utilization for the Obligated Group

A summary of certain acute care utilization data for the Obligated Group is presented for the years ended December 31:

EXHIBIT 2.2 - DATA PRESENTED YEAR TO DATE; IN THOUSANDS UNLESS NOTED	2018	2017
Obligated Group		
Total Acute Admissions	504	516
Acute Patient Days	2,395	2,391
Long-term Patient Days	402	387
Outpatient Visits (incl. Physicians)	21,450	20,899
Emergency Room Visits	2,089	2,119
Total Surgeries and Procedures	561	558
Acute Average Daily Census (actual)	6,562	6,552

Non-obligated group system affiliates

In addition to the Obligated Group Members, the System includes: health plans; a provider network; numerous fundraising foundations; Providence Ventures, Inc., a Washington corporation that invests in health care activities; various not-for-profit corporations that own and operate assisted living facilities and

low-income housing projects, including housing facilities for the elderly; and the University of Providence formerly known as University of Great Falls, located in Great Falls, Montana. The System also includes multiple operations involving or supporting home health, outpatient surgery, imaging services and other professional services provided through for-profit and non-profit entities that are not part of the Obligated Group. These entities are organized as subsidiaries of the System, partnerships or joint ventures with other entities. Obligated Group Members also may engage in informal alliances and/or contract-based physician relationships. Affiliates that are not Obligated Group Members are referred to in this Annual Report as the "*Non-Obligated Group System Affiliates*." Certain Non-Obligated Group System Affiliates that are of significant operational or strategic importance and other Non-Obligated Group System Affiliates are discussed elsewhere in this Annual Report only to the extent they are viewed by System management to be of particular operational or strategic importance.

Financial information

The summary audited combined financial information as of and for the fiscal years ended December 31, 2018 and 2017, respectively, are presented below. The financial 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.

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make assumptions, estimates and judgments that affect the amounts reported in the combined financial statements, including the notes thereto, and related disclosures of commitments and contingencies, if any. System management considers critical accounting policies to be those that require the more significant judgments and estimates in the preparation of its financial statements, including the following: recognition of net operating revenues, which includes contractual allowances; impairment of long-lived assets; valuation of investments; accounting for expenses in connection with restructuring activities; provisions for bad debt; and reserves for losses and expenses related to health care professional and general liability risks. Management relies on historical experience and on other assumptions believed to be reasonable under the circumstances in making its judgments and estimates. Actual results could differ materially from those estimates.

Summary Audited Combined Statements of Operations

EXHIBIT 3.1 - DATA PRESENTED YEAR TO DATE; PRESENTED IN MILLIONS	2018	2017	VARIANCE
Net Patient Service Revenues	18,998	17,867	1,131
Premium and Capitation Revenues	4,359	4,079	280
Other Revenues	1,071	1,217	(146)
Total Operating Revenues	**24,428**	**23,163**	**1,265**
Salaries, Wages and Other	22,903	21,853	1,050
Depreciation	1,082	1,038	44
Interest and Amortization	278	269	9
Total Operating Expenses Before Restructuring Costs	**24,263**	**23,160**	**1,103**
Excess of Revenues Over Expenses from Operations Before Restructuring Costs	**165**	**3**	**162**
Restructuring Costs	162	-	162
Excess of Revenues Over Expenses from Operations	**3**	**3**	**-**
Net Non-operating (Losses) Gains	(448)	777	(1,225)
(Deficit) Excess of Revenues Over Expenses	**(445)**	**780**	**(1,225)**
Operating EBIDA	**1,363**	**1,310**	**53**
Pro Forma Operating EBIDA [1]	**1,525**	**1,209**	**316**

(1) Pro forma operating EBIDA normalizes for one-time anomalies, including restructuring costs of $162 million in 2018 and the PAML transaction in 2017 of $101 million

Summary Audited Combined Balance Sheets

EXHIBIT 3.2 - PRESENTED IN MILLIONS	2018	2017	VARIANCE
ASSETS			
Current Assets:			
Cash and Cash Equivalents	1,597	1,371	226
Short-term Investments	511	414	97
Accounts Receivable, Net	2,257	2,222	35
Other Current Assets	1,151	1,434	(283)
Current Portion of Funds Held by Trustee	143	66	77
Total Current Assets	**5,659**	**5,507**	**152**
Assets Whose Use Is Limited:			
Long-term Investments	9,135	9,526	(391)
Other Restricted Assets	464	460	4
Total Assets Whose Use Is Limited	**9,599**	**9,986**	**(387)**
Property, Plant and Equipment, Net	10,871	10,955	(84)
Total Other Assets	1,300	1,197	103
Total Assets	**27,429**	**27,645**	**(216)**
LIABILITIES AND NET ASSETS			
Current Liabilities:			
Master Trust Debt classified as Short-term	110	57	53
Accounts Payable	1,098	684	414
Accrued Compensation	1,202	1,111	91
Other Current Liabilities	2,135	2,369	(234)
Total Current Liabilities	**4,545**	**4,221**	**324**
Long-term Debt, Net of Current Portion	6,258	6,485	(227)
Other Long-term Liabilities	2,235	2,193	42
Total Liabilities	**13,038**	**12,899**	**139**
Net Assets:			
Net Assets without Donor Restrictions	13,156	13,545	(389)
Net Assets with Donor Restrictions	1,235	1,201	34
Total Net Assets	**14,391**	**14,746**	**(355)**
Total Liabilities and Net Assets	**27,429**	**27,645**	**(216)**

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 increasing understanding of the combined financial statements. The audited combined financial information as of and for the fiscal years ended December 31, 2018 and 2017, respectively, are presented below. The following document is incorporated herein by reference and are available for review on the Electronic Municipal Market Access (*EMMA*) website of the Municipal Securities Rulemaking Board (*MSRB*): *Providence St. Joseph Health, Continuing Disclosure Annual Report, including Management's Discussion and Analysis and Results of Operations, Fiscal Year Ended December 31, 2018.*

Results of operations

Operations Summary

Operating earnings before interest, depreciation and amortization (EBIDA) was $1.4 billion and operating income was $3 million for the year ended December 31, 2018, compared with $1.3 billion and $3 million, respectively, in the same period for 2017 (as reported), and includes $162 million for restructuring costs comprised of asset impairment, severance, and consulting expenses as part of a system-wide effort to streamline operations and improve productivity. Pro forma operating EBIDA, normalized for restructuring costs in 2018 and the gain related to sale of Pathology Associates Medical Laboratories, LLC (PAML) in 2017, increased $316 million and $263 million, respectively, for the year ended December 31, 2018, compared with the same period in 2017. The net increase was driven by overall higher acuity and volumes growth, increased rates in outpatient and inpatient settings, improvements from expense reduction initiatives, and higher labor productivity. The increase in volumes drove corresponding increases in labor and supply costs. Operating EBIDA before restructuring costs was also impacted by the recognition of provider tax programs in 2018. The System's key financial indicators are presented below both as reported and pro forma for the years ended December 31:

	AS REPORTED			PRO FORMA [1]		
EXHIBIT 3.3 - DATA PRESENTED YEAR TO DATE; $ FIGURES PRESENTED IN MILLIONS	2018	2017	VARIANCE	2018	2017	VARIANCE
Operating Income (Loss)	3	3	-	165	(98)	263
Operating Margin %	0.0	0.0	0.0	0.7	(0.4)	1.1
Operating EBIDA	1,363	1,310	53	1,525	1,209	316
Operating EBIDA Margin %	5.6	5.7	(0.1)	6.2	5.2	1.0
Net Service Revenue/Case Mix Adjusted Admits	12,066	11,652	414	12,066	11,548	518
Expense/Case Mix Adjusted Admits	12,064	11,650	414	11,902	11,647	255
Debt to Cash Flow	7.0	3.1	3.9	5.9	3.3	2.6
Total Community Benefit (millions)	1,595	1,601	(6)	-	-	-
Full-time Equivalents (thousands)	105	103	2	-	-	-

(1) 2018 pro forma normalizes for restructuring costs, including $162 million for operating expenses, operating income and operating EBIDA; and 2017 normalizes for the PAML transaction, including $104 million for operating revenues, $3 million for operating expenses, and $101 million for operating income and operating EBIDA

Volumes

The System experienced four percent higher volumes per case mix adjusted admissions (CMAA) for the year ended December 31, 2018, compared with the same period in 2017, driven by growth in the outpatient setting and increased patient acuity. Outpatient visits grew five percent for the year ended December 31, 2018, compared with the same period in 2017, primarily due to a nine percent increase in the physician visits. The System's key volume indicators are presented for the years ended December 31:

EXHIBIT 3.4 - DATA PRESENTED YEAR TO DATE	2018	2017	VARIANCE
Inpatient Admissions	514	522	(8)
Acute Adjusted Admissions	1,025	1,002	23
Acute Patient Days	2,441	2,420	21
Long-term Patient Days	413	399	14
Outpatient Visits (incl. Physicians)	26,915	25,648	1,267
Emergency Room Visits	2,108	2,119	(11)
Total Surgeries and Procedures	625	613	12
Acute Average Daily Census (actual)	6,688	6,631	57
Providence Health Plan Members	648	648	-

The Providence Health Plan enrollment remained consistent compared with the prior year. Connected lives member months, a measure of the number of individuals participating in the plan each month, were eight million for the Providence Health Plan, an increase of two percent for the year ended December 31, 2018, compared with the same period in 2017.

Operating Revenues

Operating revenues for the year ended December 31, 2018 was $24 billion, an increase of five percent, compared with the same period in 2017, driven by higher patient volumes and higher acuity levels. Capitation and premium revenues represented 18 percent of total operating revenues, and grew seven percent for the year ended December 31, 2018, compared with the same period in 2017. The System's operating revenues by state is presented for the years ended December 31:

EXHIBIT 3.5 - OPERATING REVENUES BY STATE [1]	2018	2017	VARIANCE
Alaska	851	818	33
Washington	6,724	6,550	174
Montana	433	415	18
Oregon	5,091	4,791	300
California	8,684	7,966	718
Texas	1,574	1,406	168
Total Revenues from Contracts with Customers	23,357	21,946	1,411
Other Revenues	1,071	1,217	(146)
Total Operating Revenues	24,428	23,163	1,265

The System's operating revenues by line of business is presented for the years ended December 31:

EXHIBIT 3.6 - OPERATING REVENUES BY LINE OF BUSINESS [1]	2018	2017	VARIANCE
Hospitals	16,187	15,344	843
Heath Plans and Accountable Care	3,212	2,993	219
Physician and Outpatient Activities	2,726	2,451	275
Long-term Care, Home Care, and Hospice	990	845	145
Other	242	313	(71)
Total Revenues from Contracts with Customers	23,357	21,946	1,411
Other Revenues	1,071	1,217	(146)
Total Operating Revenues	24,428	23,163	1,265

Net patient revenues per case mix adjusted admissions increased four percent for the year ended December 31, 2018, compared with the same period in 2017. As a percent of total net patient revenues, Medicaid increased compared with the prior year mostly from an increase in Medicaid revenues from the recognition of provider tax programs in 2018. The System's net patient revenues by payor mix is presented for the years ended December 31:

EXHIBIT 3.7 - PAYOR NET PATIENT REVENUES [1]	2018	2017	VARIANCE
Commercial	11,503	11,041	462
Medicare	7,540	7,311	229
Medicaid	3,781	3,041	740
Self-pay and Other	533	553	(20)
Total Revenues from Contracts with Customers	23,357	21,946	1,411
Other Revenues	1,071	1,217	(146)
Total Operating Revenues	24,428	23,163	1,265

[1] Prepared in accordance with U.S. GAAP upon adoption of ASC 606, Revenue from Contracts with Customers

Operating Expenses

Operating expenses for the year ended December 31, 2018 were $24 billion, an increase of five percent compared with the same period in 2017, driven mainly by costs associated with serving the System's higher volumes, restructuring charges, and adjustments related to the California provider tax program. Restructuring costs related to asset rationalization, employee reductions and other items were incurred to drive future operating performance. Salaries and wages expense increased four percent for the year ended December 31, 2018, compared with the same period in 2017, driven by full-time equivalent ("FTE") growth of two percent. On an adjusted occupied bed volumes basis, labor productivity improved three percent, compared with the prior year. Supplies expense increased five percent for the year ended December 31, 2018, driven primarily by a 10 percent increase in pharmaceutical spend offset by a two percent decline in medical supply costs per CMAA compared with the prior year.

Non-Operating Activity

Non-operating activity is primarily comprised of investment income, pension settlement costs, and expenses for innovation projects. Non-operating losses totaled $448 million for the year ended December 31, 2018, compared with non-operating gains of $777 million for the same period in 2017. The decrease was primarily driven by weaker market performance for the year ended December 31, 2018, compared with relatively strong market performance over the same period in 2017.

Liquidity and capital resources

Unrestricted Cash and Investments

Unrestricted cash reserves totaled over $11.2 billion as of December 31, 2018, compared to $11.3 billion for the prior year, and includes cash generated from operations, debt service costs, capital spending and investment activity. The System's liquidity of the System is presented for the years ended December 31:

EXHIBIT 4.1 - DATA PRESENTED YEAR TO DATE	2018	2017	VARIANCE
Cash and Cash Equivalents	1,597	1,371	226
Short-term Investments	511	414	97
Long-term Investments	9,135	9,526	(391)
Total Unrestricted Cash and Investments	11,243	11,311	(68)

The System maintains a long-term investment program (the "Program") comprised of three funds: the health care facilities, the foundations and PHP, respectively. Each fund may maintain its own investment and asset allocation policies. The table below includes the target asset allocation of the Program investment portfolio, by general asset class, for the years ended December 31:

EXHIBIT 4.2 - DATA PRESENTED YEAR TO DATE	2018	2017	VARIANCE
Cash and Cash Equivalents	2%	2%	-
Domestic and International Equities	45%	45%	-
Debt Securities	33%	33%	-
Other Securities	20%	20%	-

Financial Ratios

The System's financial ratios is presented for the years ended December 31:

EXHIBIT 4.3 - DATA PRESENTED YEAR TO DATE	2018	2017	VARIANCE
Total Debt to Capitalization %	32.6	32.6	(0.0)
Current Debt Service Coverage	4.4	3.3	1.1
Cash to Debt Ratio %	176.6	172.9	3.7
Cash to Comprehensive Debt %	118.4	114.4	4.0
Days Cash on Hand [1]	178	189	(11)
Cushion Ratio	29	29	-
Maximum Annual Debt Service ("MADS")	390	384	6
Comprehensive Debt to Capitalization %	41.9	42.2	(0.3)
Cash to Total Net Asset Ratio	0.85	0.84	0.01

[1] Day Cash on Hand, a measure of cash in relation to monthly operating expenses, is calculated as follows: (Unrestricted cash & investments) / ((total operating expenses - depreciation and amortization expenses)/days outstanding during the periods. The years presented were restated to normalize for one-time anomalies.

Capitalization

The System's capitalization of the System is presented for the years ended December 31:

EXHIBIT 4.4 - DATA PRESENTED YEAR TO DATE; $ FIGURES PRESENTED IN MILLIONS	2018	2017	VARIANCE
Long-term Indebtedness	6,558	6,564	(6)
Less: Current Portion of Long-term Debt	300	79	221
Net Long-term Debt	6,258	6,485	(227)
Net Assets - Unrestricted	13,156	13,545	(389)
Total Capitalization	19,414	20,030	(616)
Long-term Debt to Capitalization %	32.2%	32.4%	(0.2%)

The System's coverage of MADS on indebtedness is presented for the years ended December 31:

EXHIBIT 4.5 - DATA PRESENTED YEAR TO DATE; $ FIGURES PRESENTED IN MILLIONS	2018	2017	VARIANCE
Income Available for Debt Service:			
(Deficit) Excess of Revenues Over Expenses	(445)	780	(1,225)
Plus: Unrealized Losses/Less: Unrealized (Gains) on Trading Securities	652	(595)	1,247
Plus: Loss on Extinguishment of Debt	6	-	6
Plus: Loss on Pension Settlement Costs and Other	26	25	1
Plus: Depreciation	1,082	1,038	44
Plus: Interest and Amortization	278	269	9
Total	1,599	1,517	82
Debt Service Requirements [1]:			
MADS	390	384	6
Coverage of Debt Service Requirements	4.1x	4.0x	0.1

[1] Debt Service Requirements has the meaning assigned to such term in the Master Indenture.

Credit Agency Ratings

The System received affirmation on the following ratings from the three national credit rating agencies conducted during their annual review at the end of 2017 and issued the following credit ratings:

- Fitch: "AA-"
- Standard and Poor's: "AA-"
- Moody's: "Aa3"

Governance and management

Corporate Governance

The System serves as the parent and corporate member of PH&S and SJHS. The System has obtained tax exemption under Section 501(c)(3) of the Internal Revenue Code. Prior to the Combination, the sole corporate member of PH&S was Providence Ministries, which acted through its sponsors, who are five individuals appointed by the Provincial Superior of the Sisters of Providence, Mother Joseph Province. Similarly, the sole corporate member of SJHS was St. Joseph Health Ministry, a California non-profit public benefit corporation. Providence Ministries and St. Joseph Health Ministry are each a public juridic person under Canon law, responsible for assuring the Catholic identity and fidelity to the mission of their respective Systems. Pursuant to the Combination, Providence Ministries and St. Joseph Health Ministry have entered into an agreement that establishes a sponsorship model through contractual obligations exercised by the parties' sponsors collectively (the "Sponsors Council"). The Sponsors Council retains certain reserved rights with respect to the System. Among the powers reserved to the Sponsors Council are the following powers over the affairs of the System (excluding certain affiliates, such as: Providence - Western Washington, Western HealthConnect, Swedish, Swedish Edmonds, PacMed, Kadlec and Hoag Hospital): to amend or repeal the articles of incorporation or bylaws of the System; the appointment and removal, with or without cause, of the directors of the System; the appointment and removal, with or without cause, of the President and Chief Executive Officer of the System; the approval of the acquisition of assets, incurrence of debt, encumbering of assets and sale of certain property of the System; the approval of operating and capital budgets, upon recommendation of the System Board of Directors; and the approval of dissolution, consolidation or merger. The System has reserved rights over PH&S and SJHS, which powers may be exercised by Board of the System.

The following table lists the current members of the Board of Directors and the Sponsors Council.

Board of Directors	Term Expires (December 31)
Richard Blair, Chair †	2019
David Olsen, Vice Chair ‡	2019
Dick Allen ‡	2019
Isiaah Crawford, PhD Δ	2019
Lucille Dean, SP †	2019
Diane Hejna, CSJ, RN. Δ	2019
Michael Holcomb ‡	2019
Phyllis Hughes, RSM, PhD. Δ	2019
Sallye Liner, MSN, RN †	2019
Mary Lyons, PhD. Δ	2019
Walter "Bill" Noce, Jr. †	2019
Carolina Reyes, M.D. Δ	2019
Phoebe Yang Δ	2019
Rod Hochman, M.D.	Ex-officio

Sponsors Council	Term Expires (December 31)
Eleanor Brewer	2020
Ned Dolejsi	2019
Jeff Flocken	2019
Barbara Savage	2019
Bill Cox	2022
Russell Danielson	2021
Sr. Sharon Becker, CSJ	2021
Sr. Barbara Schamber, SP	2019
Sr. Katherine Gray, CSJ	2019
Mark Koeing	2021

† Not eligible for an additional term.
‡ Eligible for one additional three-year term.
Δ Eligible for up to two.

Executive Leadership Team

The following leaders are members of our executive leadership team, reporting to the CEO of the System.

Name	Title
Rod Hochman, M.D.	President and CEO
Venkat Bhamidipati	EVP and CFO
Mike Butler	President of Operations and Strategy
Debra Canales	EVP and Chief Administrative Officer
Amy Compton-Phillips, M.D.	EVP and Chief Clinical Officer
Dougal Hewitt	EVP and Chief Mission Officer
Rhonda Medows, M.D.	President of Population Health Management and CEO of Ayin Solutions
Cindy Strauss	EVP and Chief Legal Officer
Sheryl Vacca	SVP and Chief Risk Officer

Support Services

Corporate officers and supporting staff oversee the management activities carried on, on a day-to-day basis, by the management staff of each region. Each regional Chief Executive reports to the President of Operations, who oversees their management with emphasis on the service area's achievements in responding to unmet health care needs in the community, especially the unmet needs of the poor, productivity, developing integrated delivery systems, meeting financial guidelines, and maintaining or increasing market share. The Chief Financial Officer of the System and Finance staff coordinate the annual budget and five-year forecasts (also updated annually) of the service areas, and manage the capital acquisition and management activities of the Obligated Group. Other areas in which the corporate staff provides centralized services or coordinates the activities of the service areas include: legal affairs, insurance and risk management, treasury services, materials management, technical support, fund raising, quality of care, medical ethics, pastoral services, mission effectiveness, human resources, planning and policy development, and public affairs.

Control of Certain Obligated Group Members

General

PH&S is the sole corporate member, directly or indirectly, of each of Providence - Washington, Providence - Southern California, LCMASC, Providence - St. John's, Providence - SJMC Montana, Providence - Montana, Providence - Oregon, Swedish, Swedish Edmonds, Pac Med, Western Health Connect and Kadlec, and co-corporate member of Providence - Western Washington.

SJHS is the sole corporate member of Redwood Memorial, St. Joseph Eureka, Santa Rosa Memorial and Queen of the Valley and, as more fully described hereinafter, a corporate member of St. Joseph Orange, St. Jude, Mission Hospital and St. Mary.

Northern California Region

SJHS is the sole member of St. Joseph Health Northern California, LLC, which as of April 1, 2018, operates and does business as Santa Rosa Memorial Hospital, Queen of the Valley Medical Center, St. Joseph Hospital of Eureka, and Redwood Memorial Hospital (the "Hospitals"). The Hospitals' corporations still exist with minimal operations. The goal is to dissolve these corporations by the end of the first quarter of 2019. St. Joseph Health Northern California, LLC, is also the sole member of SRM Alliance Hospital Services, which operates Petaluma Valley Hospital.

Southern California Region

In connection with the March 2013 affiliation of SJHS and Hoag Hospital, a new entity known as Covenant Health Network, Inc. (CHN), a California nonprofit public benefit corporation, was created. CHN is a corporate member of Hoag Hospital and St. Joseph Orange, St. Jude, Mission Hospital and St. Mary (the "SJHS Southern California Hospitals"). CHN, The George Hoag Family Foundation ("Hoag Family Foundation") and the constituent churches of the Los Ranchos Presbytery of the Presbyterian Church (USA), as represented by the Association of Presbyterian Ministers (APM), are the corporate members of Hoag Hospital. None of CHN, Hoag Family Foundation or APM is an Obligated Group Member or is obligated for payment on the Series 2018 Bonds.

SJHS, CHN, Hoag Hospital and the SJHS Southern California Hospitals entered into an affiliation pursuant to the terms of an Affiliation Agreement dated as of October 15, 2012 (the "CHN Affiliation Agreement"). The CHN Affiliation Agreement, which became effective as of March 1, 2013, is designed to allow SJHS and each of the SJHS Southern California Hospitals on the one hand, and Hoag Hospital on the other hand, to preserve their respective Catholic and Presbyterian heritages and identities while creating an integrated community health care delivery system. The Affiliation Agreement was amended June 1, 2017 and the System became a party to the arrangement. In addition, a Supplemental Agreement and two amendments were also entered into between the parties in 2017.

CHN does not have any corporate members, and neither the System, SJHS, its affiliates, nor Hoag Hospital have any ownership interest in CHN. CHN's governing board consists of seven members, four of whom are designated by the System. The remaining three members are designated by Hoag Family Foundation and APM, acting collaboratively. In accordance with the CHN Affiliation Agreement and its amendments and supplements, the System shall at all times have the right to designate at least a majority of the CHN board members. The CHN board is principally responsible for providing strategic planning leadership and oversight for each of Hoag Hospital, the SJHS Southern California Hospitals.

CHN and SJHS have certain reserved powers with respect to the governance, management and operation of each of the SJHS Southern California Hospitals and Hoag Hospital. Some of these powers may be exercised only by a supermajority vote of the CHN Board of Directors, meaning the affirmative vote of at least three of the four members designated by the System, and of at least two of the three members designated by Hoag Family Foundation and APM. These reserved powers include, among others, certain actions relating to: (i) changes in articles and bylaws, (ii) certain board member and management appointments and removals; and (iii) certain hospital mergers, acquisitions, joint ventures, asset sales, cash transfers and financings. Hoag Family Foundation and APM also have reserved powers with respect to certain management and operating matters and transactions involving Hoag Hospital.

West Texas/Eastern New Mexico Region

SJHS and Lubbock Methodist Hospital System (LMHS) are the corporate members of CHS. CHS is the sole corporate member of Covenant Children's, Covenant Levelland and Covenant Plainview. LMHS is not an Obligated Group Member and is not obligated for payment on the Series 2018 Bonds.

CHS was formed in 1998 pursuant to an affiliation between SJHS and LMHS and its affiliates, pursuant to which CHS became the sole corporate member of certain entities previously affiliated with LMHS and, together with certain of such entities, joined the obligated group to which SJHS and its affiliates were party.

CHS is governed by a 19-member board of directors. LMHS and SJHS each appoint eight directors. SJHS also appoints the Chief Executive Officer of CHS, who is an ex-officio voting director. The CHS Chief of Staff and Covenant Children's Hospital Chief of Staff also serve as ex-officio voting directors. SJHS has extensive authority with respect to the financial affairs of CHS and its subsidiaries, including, but not limited to, the approval of budgets of CHS and its subsidiaries and selection and retention of auditors.

As part of the affiliation, SJHS, CHS and LMHS entered into an agreement that significantly restricts the ability of SJHS to sever its relationship with CHS and the entities formerly affiliated with LMHS. Under certain circumstances, it also restricts CHS and SJHS from a wide variety of transactions (the "Covered Transactions"), including: (i) certain management agreements, leases, joint ventures and other transactions that might have the effect of transferring control of Covenant Medical Center or all assets of CHS and its subsidiaries to an unrelated third party, or in a manner that voids or reduces LMHS's right, as a member, to appoint directors; (ii) a sale, transfer or conveyance of all or substantially all of CHS' assets (including all of CHS' affiliates, taken in the aggregate); (iii) an affiliation, management agreement, lease or joint venture under which a third party acquires the right to control CHS, as a whole; or (iv) any other transaction in which the ability to appoint and remove more than 50 percent of the directors of CHS is transferred to a third party.

In the event SJHS or CHS undertakes a Covered Transaction, they are obligated to provide notice and information to LMHS and to make a "reciprocal offer" to LMHS, including an offer to purchase LMHS's membership rights in CHS and a simultaneous obligation to offer CHS' membership rights to LMHS at the same purchase price, adjusted upward by a formula that reflects the dissolution percentages Pursuant to the terms of the affiliation, the dissolution percentages are SJHS - 57 percent; LMHS - 43 percent.

Other information

Employees

As of December 31, 2018, the System employed approximately 115,000 caregivers (excluding Hoag), which represents approximately 105,000 FTEs. Of the total employees in the System, approximately 32 percent are represented by 17 different labor unions.

Management of the System believes the salary levels and benefits packages for its employees are competitive in all of the respective markets. At the same time, management of the System knows that the health care market is rapidly evolving. As a result, the leadership of each of the separate employers within the System is working to ensure the compensation and benefits are modern and reflect competitive market practices, which will require negotiations at various employers within the System in the first six months of 2019. In the past two years, the System has experienced strikes at different facilities, as a result of contract negotiations. In each situation, the facility operated with qualified replacement employees and did not experience any disruption to hospital operations or patient service, and ultimately settled the contract. Management is also aware of ongoing organizing efforts by labor unions in health care generally, particularly in the markets where the System operates, and at other employers in certain markets in the System.

Insurance

The System has developed insurance programs that provide coverage for the vast majority of insurable risks. The program uses benchmarking and insurance analytics to guide its decisions regarding both the type of coverage it purchases and the limits of that insurance. The analytics use claims and historical data to estimate the likelihood of certain events occurring such as an earthquake or an anti-trust claim. The premium for additional limit can then be compared to the probability of the event to pinpoint when the purchase of additional insurance limit no longer provides a value to the System. The insurance team and brokers negotiate almost all of the policies directly to obtain the most favorable terms of coverage possible. Policies are also reviewed to ensure no coverage gaps - what is excluded in one policy must be covered by a different policy. Insurers must have an A rating or better from A.M. Best to be on the System program. Management meets with most of its underwriters at least once a year to obtain updates on any changes in business strategy or capacity. The System currently self-insures a portion of its professional and general liability. Such claims are paid through trust arrangements which are funded to a 75 percent confidence level based on projections from outside independent actuaries. The major lines of insurance renewed yearly include property, directors and officers, employment practices, auto, fiduciary, cyber/information security, workers' compensation, crime, and aviation.

Retirement Plans

As described more completely under the caption "Retirement Plans" in Note 6 to the combined audited financial statements included in EXHIBIT 7, the System currently sponsors defined benefit and contribution plans. Although the System had certain defined benefit plans in place prior to January 1, 2010, in April 2009, the PH&S Board of Directors approved a freeze of the two existing defined benefit plans, a cap on the ongoing cash balance interest credit formula and the implementation of new defined contribution plans referenced within Note 6, all effective December 31, 2009.

The System's remaining unfunded liability with respect to the defined benefit plans decreased from approximately 62 percent at December 31, 2017 to 58 percent at December 31, 2018. The decrease in the unfunded liability occurred primarily due to a change in the valuation discount rate and mortality table changes. The System's contribution to the defined benefit plans was approximately $99 million and $95 million at December 31, 2018 and 2017, respectively.

The 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 System makes contributions to eligible employees based on years of service. Retirement expense related to these plans was $513 million and $478 million in December 31, 2018 and 2017, respectively, and is reflected in salaries and benefit expense in the accompanying combined statements of operations.

Compliance with California Seismic Standards

California's Hospital Seismic Safety Act (the "Seismic Safety Act") requires licensed acute care functions to be conducted only in facilities that meet specified seismic safety standards. The System has proactively worked towards seismic regulatory compliance for all of its California acute hospital facilities, as well as structural ("SPC") compliance and non-structural building systems bracing and anchorage ("NPC") compliance.

SJHS formally received seismic compliance extensions from the Office of Statewide Health Planning and Development ("OSHPD") via Senate Bill 90 for five hospital campuses with SPC1 buildings: St. Joseph Eureka; General Hospital, Eureka; and St. Jude Medical Center. The three campuses are in the process of completing the remaining required seismic compliance upgrades before January 2020. The total area of SJHS California acute care facilities is just under 3 million square feet. Of that total area, approximately 93 percent is already in seismic compliance with the extended January 2020 deadline, and that same area is approximately 56 percent seismically compliant with the 2030 deadline.

Relative to non-structural (building system bracing) compliance status, seven of the SJHS acute care facilities received exemption through January 2030 under Senate Bill 499, and three SJHS campuses are fully NPC compliant through January 2030, which leaves one remaining campus. This campus was granted an NPC 3 exemption until January 2020, and it is almost fully NPC compliant through January 2030 except for one area under construction, which will be completed by January 2020. Upon completion of work this hospital will then be NPC compliant through 2030. Hoag Hospital has also been actively achieving compliance with the Seismic Safety Act, 100 percent of the 1 million square feet Newport Beach campus are fully compliant with seismic standards of inpatient care to 2030. Seven buildings are currently classified as SPC-2, which would need to be either upgraded to SPC-4D or removed from providing acute-care services by 2030. In addition, there are 17 buildings at the campus that are currently classified as NPC-2. These would need to be upgraded and reclassified to NPC-5 by 2030 and meets the requirements of the Seismic Safety Act. The Irvine campus of Hoag Hospital has OSHPD approval for use as an acute care facility to 2030 and beyond from a structural (i.e. SPC) perspective. Both of the existing buildings at the Irvine campus of Hoag Hospital are currently classified as NPC-2 and would need to be upgraded and reclassified to NPC-5 by January 1, 2030.

Providence - Saint John's is seismically compliant to January 2030 and beyond. Providence Little Company of Mary Medical Center Torrance, Providence St. Joseph Medical Center and Providence Holy Cross Medical Center are seismically compliant until January 2030, and with additional work these three campuses would be compliant beyond 2030. Providence Tarzana Medical Center has three seismically noncompliant buildings which do not currently meet the seismic regulations; however, they received seismic compliance extensions through both January 2020 and October 2020 via SB 90 and AB 908, respectively.

The two Providence Little Company of Mary Medical Center San Pedro seismically noncompliant buildings were also granted extensions via SB 90. Construction on the Tarzana and San Pedro buildings began in 2017.

Finally, in light of the newly adopted Structural Performance Category 4D (SPC-4D) classification, the System is proactively evaluating several SPC2 buildings throughout its California hospital campuses for potential SPC-4D retrofit and re-classification for use beyond the January 2030 seismic compliance deadline. While it is too early to get definitive OSHPD review to determine the full impact, the retrofit and SPC-4D reclassification of those approved buildings will mitigate some of the longer term, January 2030 hospital replacement requirements and capital expenditures.

Community Benefit

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.

Building on our commitment to care for those who are poor and vulnerable, we have invested $1.6 billion in community benefit in each of the past two years demonstrating our commitment to the communities we serve. In an environment of decreased reimbursement for government-sponsored medical care, community benefit spending related to the unpaid costs of Medicaid was $0.9 billion for the year ended December 31, 2018, compared with $1.0 billion for the same period in 2017.

Interest Rate Swap Arrangements

The System and/or certain of its affiliates enter into interest rate swap contracts from time to time to increase or decrease variable rate debt exposure, to achieve a targeted mix of fixed and floating rate indebtedness and for other purposes. At December 31, 2018, SJHS was party to seven interest rate swap agreements with a current notional amount totaling approximately $453 million and with varying expiration dates. The swap agreements require SJHS to make fixed rate payments in exchange for variable rate payments made by the counterparties. The market risk exposure of these agreements occurs when the fixed rate paid is greater than the variable rate received. At December 31, 2018, the total fair value of the combined interest rate swaps of approximately $84 million represents the estimated amount SJHS would have paid upon termination of these agreements as of that date. Fair values are 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, also taking into account any nonperformance risk. Changes in the fair value of the interest rate swaps are included within non-operating gains and losses. As of December 31, 2018, SJHS has no collateral requirement.

Litigation

Certain material litigation may result in an adverse outcome to the System. The System is involved in litigation and regulatory investigations arising in the course of doing business. After consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on the System's future consolidated financial position or results of operations.

A number of civil actions are pending or threatened against certain Affiliates, including Obligated Group Members, alleging medical malpractice. In the opinion of management of the System, based upon the advice of legal counsel and risk management personnel, the probable recoveries in these proceedings and the estimated costs and expenses of defense will be within applicable insurance limits or will not materially adversely affect the business or properties of the System.

Accreditation and Memberships

The System's acute care hospital facilities are appropriately licensed by applicable state licensing agencies, certified for Medicare and Medicaid/Medi-Cal reimbursement, and (except Covenant Levelland, Providence Seward Medical Center, Providence Valdez Medical Center and Swedish Issaquah) accredited by The Joint Commission. Each long-term care facility or unit is licensed by applicable state licensing agencies and is appropriately certified for Medicare and Medicaid/Medi-Cal reimbursement.

EXHIBIT 5
LIST OF BONDS TO WHICH REPORT RELATES

Alaska Industrial Development and Export Authority Revenue Bonds (Providence Health & Services) Series 2011A, issued in the original principal amount of $122,720,000;

California Health Facilities Financing Authority Revenue Bonds (St. Joseph Health System) Series 2009 A and B, issued in the original principal amount of $254,410,000;

California Health Facilities Financing Authority Revenue Bonds (Providence Health & Services) Series 2009B, issued in the original principal amount of $150,000,000;

California Health Facilities Financing Authority Variable Rate Refunding Revenue Bonds (St. Joseph Health System) Series 2009 C and D, issued in the original principal amount of $166,690,000;

California Heath Facilities Financing Authority Revenue Bonds (St. Joseph Health System) Series 2013 A, B, C, and D, issued in the original principal amount of $654,840,000;

California Health Facilities Financing Authority Revenue Bonds (Providence Health & Services) Series 2014A, issued in the original principal amount of $275,850,000;

California Health Facilities Financing Authority Revenue Bonds (Providence Health & Services) Series 2014B, issued in the original principal amount of $118,740,000;

California Health Facilities Financing Authority Revenue Bonds (Providence St. Joseph Health) Series 2016A, issued in the original principal amount of $448,165,000;

California Health Facilities Financing Authority Revenue Bonds (Providence St. Joseph Health) Series 2016B1, issued in the original principal amount of $95,240,000;

California Health Facilities Financing Authority Revenue Bonds (Providence St. Joseph Health) Series 2016B2, issued in the original principal amount of $95,245,000;

California Health Facilities Financing Authority Revenue Bonds (Providence St. Joseph Health) Series 2016B3, issued in the original principal amount of $95,245,000;

Lubbock Health Facilities Development Corporation Variable Rate Refunding Revenue Bonds (St. Joseph Health System), Series 2008B, issued in the original principal amount of $105,385,000;

Lubbock Health Facilities Development Corporation Revenue Bonds Direct Obligation Notes (Providence St. Joseph Health) Series 2016C, issued in the original principal amount of $39,215,000;

Montana Facility Finance Authority Direct Obligation Bonds (Providence St. Joseph Health) Series 2016F, issued in the original Principal amount of $50,810,000;

Oregon Facilities Authority Revenue Bonds (Providence Health & Services) Series 2011C, issued in the original principal amount of $22,355,000;

Oregon Facilities Authority Revenue Bonds (Providence Health & Services) Series 2013A, issued in the original principal amount of $78,190,000;

Oregon Facilities Authority Revenue Bonds (Providence Health & Services) Series 2015C, issued in the original principal amount of $71,070,000;

Washington Health Care Facilities Authority Revenue Bonds (Providence Health & Services) Series 2010A, issued in the original principal amount of $174,240,000;

Washington Health Care Facilities Authority Revenue Bonds (Providence Health & Services) Series 2011B, issued in the original principal amount of $91,170,000;

Washington Health Care Facilities Authority Revenue Bonds (Providence Health & Services) Series 2012A, issued in the original principal amount of $511,370,000;

Washington Health Care Facilities Authority Revenue Bonds (Providence Health & Services) Series 2012B, issued in the original principal amount of $100,000,000;

Washington Health Care Facilities Authority Revenue Bonds (Providence Health & Services) Series 2012C, issued in the original principal amount of $80,000,000;

Washington Health Care Facilities Authority Revenue Bonds (Providence Health & Services) Series 2012D, issued in the original principal amount of $80,000,000;

Washington Health Care Facilities Authority Revenue Bonds (Providence Health & Services) Series 2014C, issued in the original principal amount of $92,245,000;

Washington Health Care Facilities Authority Revenue Bonds (Providence Health & Services) Series 2014D, issued in the original principal amount of $178,770,000;

Washington Health Care Facilities Authority Revenue Bonds (Providence Health & Services) Series 2015A, issued in the original principal amount of $77,635,000;

Washington Health Care Facilities Authority Revenue Bonds Direct Obligation Notes (Providence St. Joseph Health) Series 2016D, issued in the original principal amount of $105,430,000;

Washington Health Care Facilities Authority Revenue Bonds Direct Obligation Notes (Providence St. Joseph Health) Series 2016E, issued in the original principal amount of $105,430,000;

Washington Health Care Facilities Authority Revenue Bonds (Providence St. Joseph Health) Series 2018B, issued in the original principal amount of $141,690,000;

Taxable Bonds Direct Obligation Notes (Providence Health & Services) Series 2005, issued in the original principal amount of $60,000,000;

Taxable Bonds Direct Obligation Notes (Providence Health & Services) Series 2009A, issued in the original principal amount of $250,000,000;

Taxable Bonds Direct Obligation Notes (Providence Health & Services) Series 2012E, issued in the original principal amount of $239,760,000;

Taxable Bonds Direct Obligation Notes (Providence Health & Services) Series 2013D, issued in the original principal amount of $252,285,000;

Taxable Bonds Direct Obligation Notes (Providence St. Joseph Health) Series 2016G, issued in the original principal amount of $100,000,000;

Taxable Bonds Direct Obligation Notes (Providence St. Joseph Health) Series 2016H, issued in the original principal amount of $300,000,000;

Taxable Bonds Direct Obligation Notes (Providence St. Joseph Health) Series 2016I, issued in the original principal amount of $400,000,000;

Taxable Bonds Direct Obligation Notes (Providence St. Joseph Health) Series 2018A, issued in the original principal amount of $350,000,000

EXHIBIT 6
OBLIGATED GROUP

A list of the System's acute care facilities in each region as of December 31, 2018, each of which is owned or operated by an Obligated Group Member, is provided in Exhibit 6.1 below.

EXHIBIT 6.1 - List of Acute Care Facilities by Region

Region	Obligated Group Member	Facility	Location(s)	Licensed Acute Care Beds*
Alaska				
	Providence Heath & Services-Washington	Providence Alaska Medical Center	Anchorage	401
		Providence Kodiak Island Medical Center[1]	Kodiak	25
		Providence Seward Medical and Care Center[1]	Seward	6
		Providence Valdez Medical Center[1]	Valdez	11
Swedish				
	Swedish Edmonds	Swedish Edmonds[2]	Edmonds	217
		Swedish Medical Center Campuses[3]:		
	Swedish Health Services	Swedish Ballard	Ballard	133
		Swedish Issaquah	Issaquah	144
		Swedish Cherry Hill	Seattle	385
		Swedish First Hill	Seattle	697
Washington and Montana				
	Providence Heath & Services-Washington	Providence Centralia Hospital	Centralia	128
		Providence Regional Medical Center Everett	Everett	530
		Providence St. Peter Hospital[4]	Olympia	390
	Providence Heath & Services-Washington	Providence St. Joseph's Hospital	Chewelah	65
		Providence Mount Carmel Hospital	Colville	55
		Providence Sacred Heart Medical Center and Children's Hospital	Spokane	719
		Providence Holy Family Hospital	Spokane	197
		Providence St. Mary Medical Center	Walla Walla	142
	Kadlec Regional Medical Center	Kadlec Regional Medical Center	Richland	270
	Providence Heath & Services-Montana	St. Patrick Hospital	Missoula (MT)	253
	Providence St. Joseph Medical Center	Providence St. Joseph Medical Center	Polson (MT)	22
Oregon				
	Providence Heath & Services-Oregon	Providence Hood River Memorial Hospital	Hood River	25
		Providence Medford Medical Center	Medford	168
		Providence Milwaukie Hospital	Milwaukie	77
		Providence Newberg Medical Center	Newberg	40
		Providence Willamette Falls Medical Center	Oregon City	143
		Providence St. Vincent Medical Center	Portland	523
		Providence Portland Medical Center	Portland	483

Region	Obligated Group Member	Facility	Location(s)	Licensed Acute Care Beds*
		Providence Seaside Hospital[5]	Seaside	25
Northern California				
	St. Joseph Health Northern California, LLC.	St. Joseph Hospital	Eureka	153
		Redwood Memorial Hospital	Fortuna	35
		Queen of the Valley Medical Center	Napa	208
		Santa Rosa Memorial Hospital	Santa Rosa	298
Southern California				
	Providence Health System-Southern California	Providence St. Joseph Medical Center	Burbank	392
		Providence Holy Cross Medical Center	Mission Hills	329
		Providence Little Company of Mary Medical Center San Pedro	San Pedro	183
		Providence Tarzana Medical Center	Tarzana	246
		Providence Little Company of Mary Medical Center Torrance	Torrance	327
	Providence Saint John's Health Center	Providence Saint John's Health Center	Santa Monica	266
	St. Mary Medical Center	St. Mary Medical Center	Apple Valley	212
	St. Jude Medical Hospital, Inc.	St. Jude Medical Center	Fullerton	320
		Mission Hospital Regional Medical Center Campuses[6]:		523
	Mission Hospital Regional Medical Center	Mission Hospital Regional Medical Center	Mission Viejo	
		Mission Hospital Laguna Beach	Laguna Beach	
		Hoag Memorial Hospital Presbyterian Campuses[7]:		588
	Hoag Memorial Hospital Presbyterian	Hoag Memorial Hospital Presbyterian	Newport Beach	
		Hoag Hospital Irvine	Irvine	
	St. Joseph Hospital of Orange	St. Joseph Hospital of Orange[8]	Orange	463
Texas				
	Methodist Hospital Levelland	Covenant Hospital Levelland	Levelland	48
	Covenant Health System	CHS Campuses:		506
		Covenant Medical Center	Lubbock	
		Covenant Medical Center - Lakeside	Lubbock	
	Methodist Children's Hospital	Covenant Children's Hospital	Lubbock	269
	Methodist Hospital Plainview	Covenant Hospital Plainview	Plainview	68
TOTAL				11,708

** Includes all acute care licensure categories except for normal newborn bassinettes and partial hospitalization psychiatric beds*

(1) Leased and/or managed by Providence - Washington

(2) The legal entity Swedish Edmonds operates the hospital under a lease with Public Hospital District No. 2 of Snohomish County

(3) Four campuses with three licenses

(4) Includes a 50-bed chemical dependency center

(5) Leased to and managed by Providence - Oregon

(6) Two campuses on one license, including 36 acute care psychiatric beds in Laguna Beach

(7) Two campuses on one license

(8) Includes 37 acute care psychiatric beds

The System's principal owned or leased long-term care facilities as of December 31, 2018 is shown in Exhibit 6.2 is the table below.

EXHIBIT 6.2 - List of Long-Term Care Facilities by Region

Region	Obligated Group Member	Facility	Location(s)	Licensed Long-Term Care Beds
Facilities Owned or Leased By Obligated Group Members:				
Alaska				
	Providence Health & Services-Washington	Providence Kodiak Island Medical Center[1]	Kodiak	22
		Providence Seward Medical and Care Center[1]	Seward	40
		Providence Valdez Medical Center[1]	Valdez	10
		Providence Extended Care	Anchorage	96
		Providence Transitional Care Center	Anchorage	50
Washington and Montana				
	Providence Health & Services-Washington	Providence Marionwood	Issaquah	117
		Providence Mother Joseph Care Center	Olympia	152
		Providence Mount St. Vincent	Seattle	215
	Providence Health & Services-Washington	Providence St. Joseph Care Center	Spokane	162
Oregon				
	Providence Health & Services-Oregon	Providence Benedictine Nursing Center[2]	Mt. Angel	98
		Providence Child Center	Portland	58
Northern California				
	St. Joseph Health Northern California, LLC.	Santa Rosa Memorial Hospital	Santa Rosa	31
Southern California				
	Providence Health System-Southern California	Providence Holy Cross Medical Center	Mission Hills	48
		Providence Little Company of Mary Subacute Care Center San Pedro	San Pedro	125
		Providence Little Company of Mary Transitional Care Center	Torrance	115
		Providence St. Elizabeth Care Center	North Hollywood	52
Texas				
	Covenant Health System	Covenant Long-term Acute Care	Lubbock	56
TOTAL				1,447

(1) Leased and/or managed by Providence - Washington

(2) Also includes 15 adult foster care units

EXHIBIT 7
Providence St. Joseph Health
Supplementary Information and Audited Consolidated Financial Statements

IT 7.1 - SUMMARY AUDITED COMBINED STATEMENTS OF OPERATIONS

	Ended December 31, 2018 (in 000's of dollars)		Ended December 31, 2017 (in 000's of dollars)	
	Consolidated	Obligated	Consolidated	Obligated
Revenues:				
:e Revenues	$ 18,997,848	$ 18,327,589	$ 17,866,609	$ 17,387,036
ınd Capitation Revenues	4,359,053	751,726	4,079,290	772,317
:rating Revenues	1,071,355	1,016,425	1,217,346	1,071,744
ıting Revenues	24,428,256	20,095,740	23,163,245	19,231,097
Expenses:				
Vages and Benefits	11,919,949	10,679,907	11,464,879	10,391,082
	3,562,637	3,311,462	3,389,917	3,194,180
on	1,082,443	1,009,534	1,037,984	974,623
ıd Amortization	277,582	263,679	269,042	257,793
enses	7,420,104	4,064,273	6,998,330	3,826,726
rating Expenses Before Restructuring Costs	24,262,715	19,328,855	23,160,152	18,644,404
Revenues Over Expenses from Operations				
Restructuring Costs	165,541	766,885	3,093	586,693
ing Costs	162,146	162,146	-	-
Revenues Over Expenses from Operations	3,395	604,739	3,093	586,693
perating (Losses) Gains	(447,788)	(422,537)	776,859	769,305
Excess of Revenues Over Expenses	$ (444,393)	$ 182,202	$ 779,952	$ 1,355,998

IT 7.2 - SUMMARY AUDITED COMBINED STATEMENTS OF CASH FLOWS

	Ended December 31, 2018 (in 000's of dollars)		Ended December 31, 2017 (in 000's of dollars)	
	Consolidated	Obligated	Consolidated	Obligated
rovided by operating activities	$ 1,348,012	$ 1,834,510	$ 1,268,066	$ 2,314,546
ısed in investing activities	(1,233,858)	(884,078)	(1,027,427)	(814,554)
rovided by (used in) financing activities	112,054	(710,270)	130,363	(1,263,649)
decrease) in cash and cash equivalents	226,208	240,162	371,002	236,343
cash equivalents, beginning of period	1,371,189	786,926	1,000,187	550,583
cash equivalents, end of period	$ 1,597,397	$ 1,027,088	$ 1,371,189	$ 786,926

IT 7.3 - SUMMARY AUDITED NET PATIENT REVENUE PAYOR MIX

	Ended December 31, 2018 (in 000's of dollars)		Ended December 31, 2017 (in 000's of dollars)	
	Consolidated	Obligated	Consolidated	Obligated
ial	49%	49%	50%	50%
	32%	32%	33%	33%
	17%	16%	14%	15%

Providence
St.Joseph Health

EXHIBIT 7.4 - SUMMARY AUDITED COMBINED BALANCE SHEETS

	As of December 31, 2018 (in 000's of dollars)		As of December 31, 2017 (in 000's of dollars)	
	Consolidated	Obligated	Consolidated	Obligated
Current Assets:				
Cash and Cash Equivalents	$ 1,597,397	$ 1,027,088	$ 1,371,189	$ 786,926
Short-term Management Designated Investments	510,722	337,584	413,700	254,383
Accounts Receivable, Net	2,256,807	2,126,654	2,221,520	2,147,724
Other Current Assets	1,150,855	1,070,993	1,434,329	1,373,457
CP of Assets-Use is Limited	143,000	I,194	66,242	1,532
Total Current Assets	5,658,781	4,563,513	5,506,980	4,564,022
Assets Whose Use is Limited:				
Management Designated Cash and Investments	9,135,523	6,988,427	9,525,490	7,418,799
Other Restricted Assets	463,755	156,204	460,361	161,608
Assets Whose Use is Limited	9,599,278	7,144,631	9,985,851	7,580,407
Property Plant Equipment Net	10,870,578	10,286,917	10,955,120	10,495,562
Total Other Long-term Assets	1,300,183	1,932,833	1,196,723	1,732,368
Total Assets	$ 27,428,820	$ 23,927,894	$ 27,644,674	$ 24,372,359
Current Liabilities:				
Short-term Debt	$ 110,000	$ 110,000	$ 56,675	$ 56,675
Accounts Payable	1,097,689	983,562	684,382	623,661
Accrued Compensation	1,202,269	1,109,270	1,110,682	1,033,090
Other Current Liabilities	2,135,119	1,483,964	2,369,877	1,699,368
Total Current Liabilities	4,545,077	3,686,796	4,221,616	3,412,794
Long-Term Debt	6,257,868	6,125,953	6,484,528	6,457,366
Total Other Long-term Liabilities	2,234,915	1,549,115	2,193,453	1,562,861
Total Liabilities	13,037,860	11,361,864	12,899,597	11,433,021
Net Assets:				
Unrestricted	13,156,155	11,739,238	13,544,700	12,177,980
Restricted Net Assets	1,234,805	826,792	1,200,377	761,358
Total Net Assets	14,390,960	12,566,030	14,745,077	12,939,338
Total Liabilities and Net Assets	$ 27,428,820	$ 23,927,894	$ 27,644,674	$ 24,372,359

Providence St. Joseph Health

EXHIBIT 7.5 - KEY PERFORMANCE METRICS

	Ended December 31, 2018		Ended December 31, 2017	
	Consolidated	Obligated	Consolidated	Obligated
Total Acute Admissions	513,841	504,405	522,153	516,227
Total Acute Patient Days	2,441,202	2,395,267	2,420,196	2,391,407
Acute Outpatient Visits	12,481,103	11,796,227	12,353,677	11,759,499
Primary Care Visits	13,153,980	8,803,761	12,127,920	8,345,993
Inpatient Surgeries	223,367	217,394	226,149	221,487
Outpatient Surgeries	401,594	343,242	386,881	336,140
Long-Term Care Patient Days	413,477	401,861	398,917	387,459
Home Health Visits	1,280,207	850,032	1,166,858	793,982
Hospice Days	902,781	581,857	869,064	611,544
Housing and Assisted Living Days	622,805	247,419	612,698	248,169
Health Plan Members	648,331	n/a	647,781	n/a
Total Average Daily Census	6,688	6,562	6,631	6,552
Total Acute Licensed Beds	11,925	11,593	11,817	11,747
FTEs	105,114	93,584	103,058	93,326

7.6 - SUMMARY AUDITED COMBINING STATEMENTS OF OPERATIONS BY REGION

	Ended December 31, 2018 (in 000's of dollars)								
	Alaska	Swedish	Washington/ Montana	Oregon	Northern California	Southern California	West Texas/ Eastern New Mexico	Other/ Eliminations	Consol
'enues:									
evenues	$ 850,931	$ 2,571,368	$ 4,375,585	$ 2,483,320	$ 1,387,912	$ 6,027,805	$ 996,516	$ 304,411	$ 18
Capitation Revenues	-	-	151,044	2,362,330	61,753	1,149,793	577,794	56,339	
ıg Revenues	57,399	118,207	253,232	274,704	53,894	231,575	70,614	11,730	
Revenues	908,330	2,689,575	4,779,861	5,120,354	1,503,559	7,409,173	1,644,924	372,480	2
ıenses:									
es and Benefits	353,110	1,281,869	2,170,762	1,645,304	671,927	2,895,446	578,997	2,322,534	1
	114,235	444,274	779,090	498,446	202,245	1,021,449	227,910	274,988	
	47,438	107,746	138,421	118,223	53,766	285,011	52,562	279,276	
mortization	11,710	47,103	50,733	5,927	13,880	90,865	10,148	47,216	
es	276,759	870,538	1,673,067	2,694,962	494,973	3,037,892	732,070	(2,360,157)	
ıg Expenses Before Restructuring Costs	803,252	2,751,530	4,812,073	4,962,862	1,436,791	7,330,663	1,601,687	563,857	2
enues Over Expenses from Operations									
ructuring Costs	105,078	(61,955)	(32,212)	157,492	66,769	78,510	43,237	(191,377)	
Costs	-	-	-	-	-	-	-	162,146	
enues Over Expenses from Operations	105,078	(61,955)	(32,212)	157,492	66,768	78,510	43,237	(353,523)	
ıting (Losses) Gains	(25,987)	(20,671)	(46,384)	(63,763)	(18,399)	(88,790)	(3,406)	(180,388)	
ss of Revenues Over Expenses	$ 79,091	$ (82,626)	$ (78,596)	$ 93,729	$ 48,369	$ (10,280)	$ 39,831	$ (533,911)	$

7.7 - SUMMARY AUDITED COMBINING BALANCE SHEETS BY REGION

	As of December 31, 2018 (in 000's of dollars)								
	Alaska	Swedish	Washington/ Montana	Oregon	Northern California	Southern California	West Texas/ Eastern New Mexico	Other/ Eliminations	Consol
E									
ı Equivalents	$ 535,831	$ 133,624	$ 91,410	$ 612,595	$ 36,944	$ (504,844)	$ 234,332	$ 457,505	$
ınagement Designated Investments	-	-	-	-	531	17,834	1,973	490,384	
ɔivable, Net	124,289	335,757	520,013	243,387	151,675	731,658	150,970	(942)	
Assets	38,078	211,767	564,431	215,034	39,175	252,222	68,014	(237,866)	
n of Assets-Use is Limited	-	-	-	-	-	-	-	143,000	
rent Assets	698,198	681,148	1,175,854	1,071,016	228,325	496,870	455,289	852,081	
Use is Limited:									
Designated Cash and Investments	668,389	490,822	827,429	1,971,123	419,599	2,762,486	157,366	1,838,309	
Trustee, Gift Annuity, and Other	255	13,087	4,358	47,730	14,168	32,808	3,838	347,511	
hose Use is Limited	668,644	503,909	831,787	2,018,853	433,767	2,795,294	161,204	2,185,820	
Equipment Net	458,157	1,274,677	1,655,197	1,067,294	665,354	3,852,140	526,212	1,371,547	1
ɔng-term Assets	48,187	113,256	211,027	33,517	12,851	529,727	77,658	273,960	
ıssets	$ 1,873,186	$ 2,572,990	$ 3,873,865	$ 4,190,680	$ 1,340,297	$ 7,674,031	$ 1,220,363	$ 4,683,408	$ 2
ities:									
bt	$ -	$ -	$ -	$ -	$ 1,605	$ 91,347	$ -	$ 17,048	$
ıble	29,006	110,607	156,138	124,275	51,235	316,013	52,116	258,299	
ɔensation	33,551	97,794	180,807	131,748	47,634	295,683	53,513	361,539	
Liabilities	28,369	138,448	362,179	464,559	72,278	455,217	175,241	438,828	
rent Liabilities	90,926	346,849	699,124	720,582	172,752	1,158,260	280,870	1,075,714	
ɔbt	251,576	1,004,865	1,142,044	145,014	351,641	1,937,074	254,818	1,170,836	
ɔng-term Liabilities	29,147	433,122	43,609	44,300	7,199	169,477	35,752	1,472,309	
bilities	371,649	1,784,836	1,884,777	909,896	531,592	3,264,811	571,440	3,718,859	1
	1,483,569	690,169	1,933,406	3,077,807	749,715	3,725,032	610,977	885,480	1
Assets	17,968	97,985	55,682	202,977	58,990	684,188	37,946	79,069	
Assets	1,501,537	788,154	1,989,088	3,280,784	808,705	4,409,220	648,923	964,549	1
ıiabilities and Net Assets	$ 1,873,186	$ 2,572,990	$ 3,873,865	$ 4,190,680	$ 1,340,297	$ 7,674,031	$ 1,220,363	$ 4,683,408	$ 2

Providence St. Joseph Health

EXHIBIT 7.8 - KEY PERFORMANCE METRICS BY REGION

	As of December 31, 2018							
	Alaska	Swedish	Washington/ Montana	Oregon	Northern California	Southern California	West Texas/ Eastern New Mexico	Consolidated
Total Acute Admissions	16,558	64,803	127,367	62,148	29,442	187,465	26,058	513,841
Total Acute Patient Days	116,970	300,338	655,828	302,230	152,985	779,489	133,362	2,441,202
Acute Outpatient Visits	459,472	752,768	3,011,605	3,416,006	741,117	3,550,226	549,910	12,481,103
Primary Care Visits	137,129	1,922,747	4,053,384	2,420,400	498,088	3,568,745	553,487	13,153,980
Inpatient Surgeries	8,673	30,565	59,414	30,045	8,329	77,298	9,043	223,367
Outpatient Surgeries	12,518	52,879	115,728	63,492	17,513	115,193	24,271	401,594
Long-Term Care Patient Days	59,615	n/a	12,305	45,369	n/a	85,229	11,616	413,477
Home Health Visits	13,530	n/a	32,516	308,935	54,621	451,126	n/a	1,280,207
Hospice Days	23,594	n/a	n/a	187,370	36,002	132,372	58,391	902,781
Housing and Assisted Living Days	29,191	n/a	27,065	144,121	n/a	n/a	n/a	622,805
Health Plan Members	n/a	n/a	n/a	648,331	n/a	n/a	n/a	648,331
Total Average Daily Census	320	823	1,797	828	419	2,136	365	6,688
Total Acute Licensed Beds	485	1,576	2,743	1,484	774	3,849	1,014	11,925
FTEs	3,862	10,897	21,280	16,482	5,041	27,266	6,086	105,114

PROVIDENCE ST. JOSEPH HEALTH

Combined Financial Statements

December 31, 2018 and 2017

(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, 2018 and 2017, 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 Providence St. Joseph Health as of December 31, 2018 and 2017, and the results of its operations and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

Emphasis of Matter

As discussed in Note 1 to the combined financial statements, in 2018, Providence St. Joseph Health adopted new accounting guidance in Accounting Standards Update (ASU) No. 2014-09, *Revenue from Contracts with Customers* (Topic 606) and ASU No. 2016-14, *Presentation of Financial Statements of Not-for-Profit Entities (Topic 958)*. Our opinion is not modified with respect to this matter.

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 34 and 35 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 14, 2019

PROVIDENCE ST. JOSEPH HEALTH

Combined Balance Sheets

December 31, 2018 and 2017

(In millions of dollars)

Assets		2018	2017
Current assets:			
Cash and cash equivalents	$	1,597	1,371
Accounts receivable, less allowance for bad debts of $119 and $227, respectively		2,257	2,222
Supplies inventory		293	277
Other current assets		858	1,157
Current portion of assets whose use is limited		654	480
Total current assets		5,659	5,507
Assets whose use is limited		9,599	9,986
Property, plant, and equipment, net		10,871	10,955
Other assets		1,300	1,197
Total assets	$	27,429	27,645
Liabilities and Net Assets			
Current liabilities:			
Current portion of long-term debt	$	300	78
Master trust debt classified as short-term		110	57
Accounts payable		1,098	684
Accrued compensation		1,202	1,111
Other current liabilities		1,835	2,291
Total current liabilities		4,545	4,221
Long-term debt, net of current portion		6,258	6,485
Pension benefit obligation		1,065	1,054
Other liabilities		1,170	1,139
Total liabilities		13,038	12,899
Net assets:			
Controlling interests		12,988	13,366
Noncontrolling interests		168	179
Net assets without donor restrictions		13,156	13,545
Net assets with donor restrictions		1,235	1,201
Total net assets		14,391	14,746
Total liabilities and net assets	$	27,429	27,645

See accompanying notes to combined financial statements.

PROVIDENCE ST. JOSEPH HEALTH

Combined Statements of Operations

Years ended December 31, 2018 and 2017

(In millions of dollars)

	2018	2017
Operating revenues:		
Net patient service revenues	$ 19,109	18,136
Provision for bad debts	(111)	(269)
Net patient service revenues less provision for bad debts	18,998	17,867
Premium revenues	2,981	2,745
Capitation revenues	1,378	1,334
Other revenues	1,071	1,217
Total operating revenues	24,428	23,163
Operating expenses:		
Salaries and benefits	11,883	11,464
Supplies	3,563	3,390
Purchased healthcare services	2,414	2,539
Interest, depreciation, and amortization	1,360	1,307
Purchased services, professional fees, and other	5,043	4,460
Total operating expenses before restructuring costs	24,263	23,160
Excess of revenue over expenses from operations before restructuring costs	165	3
Restructuring costs	162	—
Excess of revenue over expenses from operations	3	3
Net nonoperating (losses) gains:		
Loss on extinguishment of debt	(6)	—
Investment (loss) income, net	(366)	882
Other	(76)	(105)
Total net nonoperating (losses) gains	(448)	777
(Deficit) excess of revenues over expenses	$ (445)	780

See accompanying notes to combined financial statements.

PROVIDENCE ST. JOSEPH HEALTH

Combined Statements of Changes in Net Assets

Years ended December 31, 2018 and 2017

(In millions of dollars)

	Without donor restrictions			
	Controlling interests	Noncontrolling interests	With donor restrictions	Total net assets
Balance, December 31, 2016	$ 12,560	200	1,036	13,796
Excess of revenues over expenses	747	33	—	780
Contributions, grants, and other	(43)	(54)	245	148
Net assets released from restriction	44	—	(80)	(36)
Pension related changes	58	—	—	58
Increase (decrease) in net assets	806	(21)	165	950
Balance, December 31, 2017	13,366	179	1,201	14,746
(Deficit) excess of expenses over revenues	(469)	24	—	(445)
Contributions, grants, and other	85	(35)	145	195
Net assets released from restriction	35	—	(111)	(76)
Pension related changes	(29)	—	—	(29)
(Decrease) increase in net assets	(378)	(11)	34	(355)
Balance, December 31, 2018	$ 12,988	168	1,235	14,391

See accompanying notes to combined financial statements.

PROVIDENCE ST. JOSEPH HEALTH

Combined Statements of Cash Flows

Years ended December 31, 2018 and 2017

(In millions of dollars)

	2018	2017
Cash flows from operating activities:		
(Decrease) increase in net assets	$ (355)	950
Adjustments to reconcile (decrease) increase in net assets to net cash provided by operating activities:		
Gain on divestiture	—	(133)
Depreciation and amortization	1,083	1,057
Provision for bad debt	111	269
Loss on extinguishment of debt	6	—
Restricted contributions and investment income received	(145)	(245)
Net realized and unrealized losses (gains) on investments	487	(761)
Changes in certain current assets and current liabilities	176	166
Change in certain long-term assets and liabilities	(15)	(35)
Net cash provided by operating activities	1,348	1,268
Cash flows from investing activities:		
Property, plant, and equipment additions, net of disposals	(857)	(1,009)
(Purchases) sales of securities, net	(71)	18
Purchases of alternative investments and commingled funds	(679)	(551)
Proceeds from sales of alternative investments and commingled funds	415	367
Cash acquired through affiliation and divestiture activities, net of cash paid	6	114
Other investing activities	(48)	34
Net cash used in investing activities	(1,234)	(1,027)
Cash flows from financing activities:		
Proceeds from restricted contributions and restricted income	145	245
Debt borrowings	566	376
Debt payments	(608)	(483)
Other financing activities	9	(8)
Net cash provided by financing activities	112	130
Increase in cash and cash equivalents	226	371
Cash and cash equivalents, beginning of year	1,371	1,000
Cash and cash equivalents, end of year	$ 1,597	1,371
Supplemental disclosure of cash flow information:		
Cash paid for interest, net of amounts capitalized	$ 277	245

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), a Washington nonprofit corporation, is the sole corporate member of Providence Health & Services (PHS) and the St. Joseph Health System (SJHS). 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 Health System seeks to improve the health of the communities it serves, especially the poor and vulnerable. The Health System operations include 51 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 2018 and 2017, 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 net assets, and cash flows reflect the Health System's financial position and results of operations as of and for the years ended December 31, 2018 and 2017.

(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 (deficit) 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.

(Continued)

(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) Restructuring Costs

Restructuring costs were recorded during the year ended December 31, 2018. The amount was comprised of asset impairment, severance, and consulting expenses related to restructuring initiatives.

(f) 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 bad debts; (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.

(g) 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.

(h) Supplies Inventory

Supplies inventory is stated at the lower of cost (first-in, first-out) or market.

(Continued)

(In millions of dollars)

(i) Property, Plant, and Equipment

Property, plant, and equipment are stated at cost. Improvements and replacements of plant and equipment are capitalized, and 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 are as follows as of December 31:

	Approximate useful life (years)	2018	2017
Land	—	$ 1,459	1,465
Buildings and improvements	5–60	10,036	9,714
Equipment:			
Fixed	5–25	1,289	1,278
Major movable and minor	3–20	6,050	5,833
Construction in progress	—	970	1,030
		19,804	19,320
Less accumulated depreciation		(8,933)	(8,365)
Property, plant, and equipment, net		$ 10,871	10,955

Construction in progress primarily represents renewal and replacement of various facilities in the Health System's operating divisions, as well as costs capitalized for software development.

(Continued)

(In millions of dollars)

(j) Other Assets

Other assets are summarized as follows as of December 31:

		2018	2017
Investment in nonconsolidated joint ventures	$	337	315
Intangible assets		236	248
Goodwill		229	190
Beneficial interest in noncontrolled foundations		176	160
Other		322	284
Total other assets	$	1,300	1,197

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 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 no goodwill impairment for the year ended December 31, 2018 and $14 during the year ended December 31, 2017.

(k) 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.

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.

(l) Liquidity

Cash and cash equivalents and accounts receivable are the primary liquid resources used by the Health System to meet expected expenditure needs within the next year. The Health System has credit facility programs, as described in Note 5, available to meet unanticipated liquidity needs. Although intended to satisfy long-term obligations, management estimates that approximately 68% of noncurrent investments, as stated at December 31, 2018, could be utilized within the next year if needed.

(Continued)

(In millions of dollars)

(m) Derivative Instruments

The Health System 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. Also, the Health System uses derivative financial instruments (interest rate swaps) to manage its interest rate exposure and overall cost of borrowing. 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 (losses) gains in the accompanying combined statements of operations.

(n) Net Assets

Net assets without donor restrictions 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 net assets without donor restrictions.

Net assets with donor restrictions are those whose use by the Health System has been limited by donors to a specific time period, in perpetuity, and/or purpose.

Net assets with donor restrictions are available for the following purposes as of December 31:

		2018	2017
Program support	$	903	821
Capital acquisition		211	197
Low-income housing and other		121	183
Total net assets with donor restrictions	$	1,235	1,201

(o) 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 contributions with donor restrictions if they are received with donor stipulations that limit the use of the donated assets. When the terms of a donor restriction are met, net assets with donor restrictions are reclassified as net assets without donor restrictions and reported as other operating revenues in the combined statements of operations or as net assets released from restriction in the combined statements of changes in net assets.

(p) 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).

(Continued)

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, 2018 and 2017 was $303 and $259, respectively.

(q) Subsequent Events

The Health System has performed an evaluation of subsequent events through March 14, 2019, the date the accompanying combined financial statements were issued.

(r) New Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2014-09, *Revenue from Contracts with Customers (Topic 606)*. The ASU replaces most existing revenue recognition guidance. The ASU was adopted on January 1, 2018 using the cumulative effect method for those contracts that were not substantially completed as of January 1, 2018. Results for reporting periods beginning on or after January 1, 2018 are presented under Topic 606, while prior period amounts continue to be presented in accordance with the Health System's historical accounting under *Revenue Recognition (Topic 605)*. The adoption of the ASU primarily changed the Health System's presentation of revenues and the provision and allowance for bad debts. The ASU requires revenue to be recognized based on the Health System's estimate of the transaction price the Health System expects to collect as a result of satisfying its performance obligations. Accordingly, for performance obligations satisfied after January 1, 2018, the Health System no longer separately presents a provision for bad debts on the combined statements of operations or the related allowance for bad debts on the combined balance sheets. However, as a result of the Health System's election to apply the ASU only to contracts not substantially completed as of January 1, 2018, the Health System continues to maintain an allowance for bad debts related to performance obligations satisfied prior to January 1, 2018. Changes to the allowance for bad debts, other than the write-offs of uncollectable accounts, are recorded through the provision for bad debts on the combined statements of operations in accordance with Topic 605. The adoption of Topic 606 did not have a significant impact on the recognition of net patient services revenues for any periods prior to adoption. Management also expects the impact of this new standard in future periods will not be significant.

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 implemented ASU 2016-01 for the fiscal year beginning January 1, 2018. The provisions of the standard did not have a material impact on the combined financial statements.

(Continued)

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. Topic 842 is effective for the Health System beginning on January 1, 2019. In 2018, the FASB updated its guidance allowing entities to adopt the provisions of the standard prospectively without adjusting comparative periods. The Health System is planning to elect this option. Management expects to record right-of-use assets and lease liabilities of approximately $1.4 billion and $1.6 billion, respectively, on its combined balance sheets. The adoption of Topic 842 is not expected to have a significant impact on the results of operations or cash flows. The Health System will include new disclosures in 2019 in accordance with Topic 842.

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 implemented ASU 2016-14 as of January 1, 2018.

The impact of adoption resulted in enhanced disclosures about the classification of expenses and management of liquid resources. As a result of adoption, temporarily restricted and permanently restricted net asset in the amounts $958 and $243, respectively, were combined to create net assets with donor restrictions as stated on the combined balance sheets as of December 31, 2017.

In March 2017, the FASB issued (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 (losses) gains on the statements of operations for the period ended December 31, 2017.

(s) 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) Affiliation 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. There were no significant affiliation activities for the years ended December 31, 2018 and 2017.

(3) Revenue Recognition

(a) 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 recognized at the time services are provided to patients. Revenue is recorded in the amount which the Health System expects to collect, which may include variable components. Variable consideration is included in the transaction price to the extent that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the variable consideration is subsequently resolved. Adjustments from finalization of prior years' cost reports and other third-party settlement estimates resulted in an increase in net patient service revenues of $6 and $27 for the years ended December 31, 2018 and 2017, respectively.

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 of Medicaid services. The taxes are included in purchased services, professional fees, and other expenses in the accompanying combined statements of operations and were $591 and $434 for the years ended December 31, 2018 and 2017, 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 $894 and $471 for the years ended December 31, 2018 and 2017, respectively.

(b) Premium and Capitation Revenues

Premium and capitation revenues are received on a prepaid basis and are recognized as revenue ratably over the period for which the enrolled member is entitled to healthcare services. The timing of the Health System's performance may differ from the timing of the payment received, which may result in the recognition of a contract asset or a contract liability. The balance of contract liabilities was $24 as of January 1, 2018 and was recognized as revenue in the combined statements of operations during 2018. The balance of contract liabilities was $29 as of December 31, 2018. The Health System has no material contract assets.

(c) Allowance for Bad Debts

As a result of adopting ASU 2014-09 as described in Note 1, the Health System continues to maintain an allowance for bad debts related to performance obligations satisfied prior to January 1, 2018.

(In millions of dollars)

The Health System provided 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 are summarized as follows for the years ended December 31:

		2018	2017
Changes in allowance for bad debts:			
Allowance for doubtful accounts at beginning of year	$	227	271
Write-off of uncollectible accounts, net of recoveries		(219)	(313)
Provision for bad debts		111	269
Allowance for bad debts at end of year	$	119	227

(d) Disaggregation of Revenue

The Health System earns the majority of its revenues from contracts with customers. Revenues and adjustments not related to contracts with customers are included in other revenue.

(In millions of dollars)

Operating revenues from contracts with customers by state are as follows for the years ended December 31:

		2018	2017
Alaska	$	851	818
Washington		6,724	6,550
Montana		433	415
Oregon		5,091	4,791
California		8,684	7,966
Texas		1,574	1,406
Total revenues from contracts with customers		23,357	21,946
Other revenues		1,071	1,217
Total operating revenues	$	24,428	23,163

Operating revenues from contracts with customers by line of business are as follows for the years ended December 31:

		2018	2017
Hospitals	$	16,187	15,344
Health plans and accountable care		3,212	2,993
Physician and outpatient activities		2,726	2,451
Long-term care, home care, and hospice		990	845
Other		242	313
Total revenues from contracts with customers		23,357	21,946
Other revenues		1,071	1,217
Total operating revenues	$	24,428	23,163

(Continued)

(In millions of dollars)

Operating revenues from contracts with customers by payor are as follows for the years ended December 31:

		2018	2017
Commercial	$	11,503	11,041
Medicare		7,540	7,311
Medicaid		3,781	3,041
Self-pay and other		533	553
Total revenues from contracts with customers		23,357	21,946
Other revenues		1,071	1,217
Total operating revenues	$	24,428	23,163

(4) 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 net asset value per share (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, 2018	Fair value measurements at reporting date using		
		Level 1	Level 2	Level 3
Management-designated cash and investments:				
Cash and cash equivalents	$ 308	308	—	—
Equity securities:				
Domestic	1,012	1,012	—	—
Foreign	317	317	—	—
Mutual funds	1,214	1,214	—	—
Domestic debt securities:				
State and federal government	1,607	951	656	—
Corporate	756	—	756	—
Other	507	—	507	—
Foreign debt securities	186	—	186	—
Commingled funds	336	336	—	—
Other	17	—	17	—
Investments measured using NAV	3,386	—	—	—
Total management-designated cash and investments	9,646			
Gift annuities, trusts, and other	184	53	12	119
Funds held by trustee:				
Cash and cash equivalents	112	112	—	—
Domestic debt securities	274	151	123	
Foreign debt securities	37	—	37	—
Total funds held by trustee	423			
Total assets whose use is limited	$ 10,253			

(Continued)

(In millions of dollars)

	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			

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 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
	2018	2017			
Hedge funds:					
Long/short equity	$ 639	579	—	Monthly, quarterly, semi-annually, or annually	30–120 days
Credit	360	300	—	Quarterly or annually	45–150 days
Relative value	208	206	—	Quarterly	60–90 days
Global macros	244	278	—	Monthly or quarterly	2–90 days
Fund of hedge funds	7	82	—	Quarterly	90 days
Private equity	372	258	566	Not applicable	Not applicable
Private real estate	155	75	240	Not applicable	Not applicable
Risk parity	84	110	—	Monthly or annually	5–60 days
Real assets	244	315	56	Monthly or quarterly	10–60 days
Commingled	1,073	1,109	—	Monthly, quarterly, or semi-annually	6–90 days
Total	$ 3,386	3,312	862		

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.

(Continued)

(In millions of dollars)

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 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) Unsettled transactions

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, 2018, the Health System recorded a receivable of $102 for investments sold but not settled and a payable of $305 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, 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.

(c) Derivative Instruments

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:

		2018	2017
Derivative assets:			
Futures contracts	$	707	275
Foreign currency forwards and other contracts		153	86
Total derivative assets	$	860	361
Derivative liabilities:			
Futures contracts	$	(707)	(275)
Foreign currency forwards and other contracts		(153)	(84)
Total derivative liabilities	$	(860)	(359)

(Continued)

(In millions of dollars)

(d) Investment (Loss) Income, Net

		2018	2017
Interest and dividend income	$	121	121
Net realized gains on sale of trading securities		165	166
Change in net unrealized (losses) gains on trading securities		(652)	595
Investment (loss) income, net	$	(366)	882

(e) 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, 2016	$	88
Total realized and unrealized losses, net		(2)
Total purchases		21
Total sales		(2)
Balance at December 31, 2017		105
Total realized and unrealized gains, net		3
Total purchases		16
Total sales		(5)
Balance at December 31, 2018	$	119

There were no significant transfers between assets classified as Level 1 and Level 2 during the years ended December 31, 2018 and 2017.

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.

(5) 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)

(Continued)

(In millions of dollars)

- Montana Facility Finance Authority (MFFA)
- Lubbock Health Facilities Development Corp (LHFDC)
- Oregon Facilities Authority (OFA)

Short-term and long-term unpaid principal consists of the following at December 31:

	Maturing through	Coupon rates	Unpaid principal 2018	Unpaid principal 2017
Master trust debt:				
Fixed rate:				
Series 2005, Direct Obligation Notes	2030	5.30–5.39%	$ 38	40
Series 2006C, WHCFA Revenue Bonds	2033	5.25	—	69
Series 2006D, WHCFA Revenue Bonds	2033	5.25	—	69
Series 2006E, WHCFA Revenue Bonds	2033	5.25	—	26
Series 2008B, LHFDC Revenue Bonds	2023	4.00–5.00	24	33
Series 2008C, CHFFA Revenue Bonds	2038	3.00–6.50	—	6
Series 2009A, Direct Obligation Notes	2019	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	5.25	26	37
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	3.50–5.00	32	42
Series 2011C, OFA Revenue Bonds	2026	3.50–5.00	13	15
Series 2012A, WHCFA Revenue Bonds	2042	3.00–5.00	471	480
Series 2012B, WHCFA Revenue Bonds	2042	4.00–5.00	100	100
Series 2013A, OFA Revenue Bonds	2024	5.00	48	54
Series 2013A, CHFFA Revenue Bonds	2037	4.00–5.00	325	325
Series 2013C, CHFFA Revenue Bonds	2043	5.00	110	110
Series 2013D, Direct Obligation Notes	2023	4.38	252	252
Series 2013D, CHFFA Revenue Bonds	2043	5.00	110	110
Series 2014A, CHFFA Revenue Bonds	2038	4.00–5.00	269	270
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
Series 2018A, Direct Obligation Bonds	2048	4.00	350	—
Series 2018B, WHCFA Revenue Bonds	2033	5.00	142	—
Total fixed rate			5,146	4,874

(Continued)

(In millions of dollars)

	Maturing through	Effective interest rate (1) 2018	Effective interest rate (1) 2017	Unpaid principal 2018	Unpaid principal 2017
Variable rate:					
Series 2012C, WHCFA Revenue Bonds	2042	1.44 %	0.86 %	$ 80	80
Series 2012D, WHCFA Revenue Bonds	2042	1.44	0.86	80	80
Series 2012E, Direct Obligation Notes	2042	1.99	1.08	226	229
Series 2013C, OFA Revenue Bonds	2022	2.30	1.79	—	57
Series 2016C, LHFDC Revenue Bonds	2030	1.98	0.86	36	37
Series 2016D, WHCFA Revenue Bonds	2036	1.95	1.34	103	106
Series 2016E, WHCFA Revenue Bonds	2036	1.88	1.26	103	106
Series 2016F, MFFA Revenue Bonds	2026	1.85	1.23	42	46
Series 2016G, Direct Obligation Notes	2047	1.97	1.08	100	100
Total variable rate				770	841
Wells Fargo Credit Facility	2019	2.39	1.73	110	110
Wells Fargo Credit Facility	2021	2.52	1.63	105	369
Unpaid principal, master trust debt				6,131	6,194
Premiums, discounts, and unamortized financing costs, net				155	148
Master trust debt, including premiums and discounts, net				6,286	6,342
Other long-term debt				382	278
Total debt				$ 6,668	6,620

(1) Variable rate debt and credit facilities carry floating interest rates attached to indexes, which are subject to change based on market conditions.

In January 2018, the Health System issued $492 of Series 2018A and 2018B 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.

In connection with the Series 2018A-B issuance, the Health System recorded losses due to extinguishment of debt of $6 in the year ended December 31, 2018, which was recorded in net nonoperating (losses) gains in the accompanying combined statements of operations.

In November 2017, the Health System obtained a Well Fargo Bridge Loan for $110 and repaid the CHFFA Series 2013B revenue bonds.

(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:

	2018	2017
Current portion of long-term debt	$ 300	78
Short-term master trust debt	110	57
Long-term debt, classified as a long-term liability	6,258	6,485
Total debt	$ 6,668	6,620

Short-term master trust debt represents debt issues with remarketing provisions unsupported by credit facilities with mandatory redemption within one year of December 31, 2018 and 2017.

(b) Other Long-Term Debt

Other long-term debt consists of the following as of December 31:

	2018	2017
Capital leases	$ 255	152
Notes payable	117	105
Bonds not under master trust indenture and other	10	21
Total other long-term debt	$ 382	278

(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
2019	$ 285	15	300
2020	80	17	97
2021	189	16	205
2022	82	16	98
2023	365	13	378
Thereafter	5,130	305	5,435
Scheduled principal payments of long-term debt	$ 6,131	382	6,513

(Continued)

(In millions of dollars)

(d) Derivative Instruments

The Health System uses interest rate swap agreements to manage interest rate risk associated with its outstanding debt. As of December 31, 2018 and 2017, the Health System had interest rate swap contracts with a total current notional amount totaling $453 and $467, respectively, with varying expiration dates. 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 (losses) gains 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, 2018 and 2017, the change in valuation was a gain of $17 and $4, respectively, and settlements recognized as a component of interest expense were $9 and $12, respectively.

Derivative financial instruments are recorded at fair value taking into consideration the Health System's and the counterparties' nonperformance risk. 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.

As of December 31, 2018 and 2017, the fair value of outstanding interest rate swaps was in a net liability position of $84 and $101, respectively, and is included in other liabilities in the accompanying combined balance sheets. The Health System had no collateral posted in connection with the outstanding swap agreements as of December 31, 2018. Collateral posted in connection with the outstanding swap agreements as of December 31, 2017 was $6 and was included in other assets in the accompanying combined balance sheets.

The following tables present the fair value of swaps and related collateral:

	December 31, 2018	Fair value measurements at reporting date using		
		Level 1	Level 2	Level 3
Liabilities under interest rate swaps	$ 84	—	84	—

	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	—

(Continued)

(In millions of dollars)

(6) 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:

		2018	2017
Change in projected benefit obligation:			
Projected benefit obligation at beginning of year	$	2,741	2,680
Service cost		27	23
Interest cost		106	114
Actuarial (gain) loss		(153)	110
Benefits paid and other		(186)	(186)
Projected benefit obligation at end of year		2,535	2,741
Change in fair value of plan assets:			
Fair value of plan assets at beginning of year		1,686	1,559
Actual return on plan assets		(130)	218
Employer contributions		99	95
Benefits paid and other		(186)	(186)
Fair value of plan assets at end of year		1,469	1,686
Funded status		(1,066)	(1,055)
Unrecognized net actuarial loss		526	495
Unrecognized prior service cost		1	3
Net amount recognized	$	(539)	(557)
Amounts recognized in the combined balance sheets consist of:			
Current liabilities	$	(1)	(1)
Noncurrent liabilities		(1,065)	(1,054)
Unrestricted net assets		527	498
Net amount recognized	$	(539)	(557)
Weighted average assumptions:			
Discount rate		4.60 %	4.00 %
Rate of increase in compensation levels		3.50	3.50
Long-term rate of return on assets		6.50	6.50

(Continued)

(In millions of dollars)

Net periodic pension cost for the defined benefit plans includes the following components:

		2018	2017
Components of net periodic pension cost:			
Service cost	$	27	23
Interest cost		106	114
Expected return on plan assets		(105)	(102)
Amortization of prior service cost		1	1
Recognized net actuarial loss		26	25
Net periodic pension cost	$	55	61
Special recognition – settlement expense	$	26	25

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, 2018 and 2017 is included in net nonoperating (losses) gains in the accompanying combined statements of operations.

The accumulated benefit obligation was $2,488 and $2,672 at December 31, 2018 and 2017, respectively.

The following pension benefit payments reflect expected future service. Payments expected to be paid over the next 10 years are as follows:

2019	$	182
2020		187
2021		192
2022		193
2023–2028		1,073
	$	1,827

The Health System expects to contribute approximately $99 to the defined benefit plans in 2019.

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% in calculating the 2018 and 2017 expense amounts. 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) were as follows at December 31:

	2018 Target	2018 ELTRA	2017 Target	2017 ELTRA
Cash and cash equivalents	2 %	2%–3%	2 %	2%–3%
Equity securities	45	7%–8%	45	7%–8%
Debt securities	33	3%–4%	33	3%–4%
Other securities	20	5%–8%	20	5%–8%
Total	100 %	6.5 %	100 %	6.5 %

The following table presents the Health System's defined benefit plan assets measured at fair value:

	December 31, 2018	Fair value measurements at reporting date using Level 1	Level 2	Level 3
Assets:				
Cash and cash equivalents	$ 81	81	—	—
Equity securities:				
Domestic	226	226	—	—
Foreign	61	61	—	—
Mutual funds	103	103	—	—
Domestic debt securities:				
State and government	266	208	58	—
Corporate	122	—	122	—
Other	15	—	15	—
Foreign debt securities	40	—	40	—
Commingled funds	141	141	—	—
Investments measured using NAV	487			
Transactions pending settlement, net	(73)			
Total	$ 1,469			

(Continued)

(In millions of dollars)

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			

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 2018	Fair value 2017	Redemption frequency	Redemption notice period
Hedge funds:				
Long/short equity	$ 43	52	Monthly or quarterly	30–65 days
Credit and other	61	56	Monthly or quarterly	90 days
Real assets	53	92	Monthly	30 days
Risk parity	108	130	Monthly	5–15 days
Commingled	222	390	Monthly	6–30 days
Total	$ 487	720		

(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:

	2018	2017
Derivative assets:		
Futures contracts	$ 724	926
Foreign currency forwards and other contracts	4	5
Total derivative assets	$ 728	931
Derivative liabilities:		
Futures contracts	$ (724)	(926)
Foreign currency forwards and other contracts	(3)	(4)
Total derivative liabilities	$ (727)	(930)

(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 $513 and $478 in 2018 and 2017, respectively, and is reflected in salaries and benefit expense in the accompanying combined statements of operations.

(7) 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.

(Continued)

(In millions of dollars)

At December 31, 2018 and 2017, the estimated liability for future costs of professional and general liability claims was $393 and $357, respectively. At December 31, 2018 and 2017, the estimated workers' compensation obligation was $351 and $309, respectively. Both are recorded in other current liabilities and other liabilities in the accompanying combined balance sheets.

(8) Commitments and Contingencies

(a) Commitments

Firm purchase commitments, primarily related to construction and equipment and software acquisition, at December 31, 2018 are approximately $534.

(b) Operating Leases

Future minimum lease commitments under noncancelable operating leases for the next five years and thereafter are as follows:

2019	$	222
2020		206
2021		183
2022		162
2023		144
Thereafter		727
	$	1,644

Rental expense, including month-to-month leases and contingent rents, was $411 and $382 for the years ended December 31, 2018 and 2017, 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 normal 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.

(Continued)

(In millions of dollars)

(9) Functional Expenses

Operating expenses classified by their natural classification on the combined statements of operations are presented by their functional classifications as follows for the years ended December 31:

	2018								
	Program Activities					Supporting Activities			
	Hospitals	Health plans and accountable care	Physician and outpatient	Long-term care, home care, and hospice	Total programs	General and administrative	Other	Total supporting	Total operating expenses
Salaries and benefits	$ 6,964	119	2,319	577	9,979	1,821	83	1,904	11,883
Supplies	2,920	1	279	114	3,314	—	249	249	3,563
Purchased healthcare services	13	2,349	36	16	2,414	—	—	—	2,414
Interest, depreciation, and amortization	815	7	78	19	919	433	8	441	1,360
Purchased services, professional fees and other	3,089	265	1,051	120	4,525	413	105	518	5,043
Restructuring costs	—	—	—	—	—	162	—	162	162
Total operating expenses	$ 13,801	2,741	3,763	846	21,151	2,829	445	3,274	24,425

	2017								
	Program Activities					Supporting Activities			
	Hospitals	Health plans and accountable care	Physician and outpatient	Long-term care, home care, and hospice	Total programs	General and administrative	Other	Total supporting	Total operating expenses
Salaries and benefits	$ 6,746	117	2,148	516	9,527	1,831	106	1,937	11,464
Supplies	2,812	1	241	97	3,151	—	239	239	3,390
Purchased healthcare services	23	2,462	38	16	2,539	—	—	—	2,539
Interest, depreciation, and amortization	810	7	78	18	913	386	8	394	1,307
Purchased services, professional fees and other	2,672	196	918	104	3,890	470	100	570	4,460
Total operating expenses	$ 13,063	2,783	3,423	751	20,020	2,687	453	3,140	23,160

Supporting activities include costs that are not controllable by operational leadership. Health System leadership drives these costs, which benefit the entire Health System. Costs that are controllable by operational leadership are allocated to the respective program activities.

PROVIDENCE ST. JOSEPH HEALTH

Supplemental Schedule – Obligated Group Combining Balance Sheets Information

December 31, 2018 and 2017

(In millions of dollars)

	2018			2017		
Assets	**Obligated Group**	**Nonobligated, eliminations, Other**	**Total combined**	**Obligated Group**	**Nonobligated, eliminations, Other**	**Total combined**
Current assets:						
Cash and cash equivalents	$ 1,027	570	1,597	787	584	1,371
Accounts receivable, net	2,127	130	2,257	2,148	74	2,222
Supplies inventory	282	11	293	270	7	277
Other current assets	789	69	858	1,103	54	1,157
Current portion of assets whose use is limited	339	315	654	256	224	480
Total current assets	4,564	1,095	5,659	4,564	943	5,507
Assets whose use is limited	7,145	2,454	9,599	7,580	2,406	9,986
Property, plant, and equipment, net	10,287	584	10,871	10,496	459	10,955
Other assets	1,932	(632)	1,300	1,732	(535)	1,197
Total assets	$ 23,928	3,501	27,429	24,372	3,273	27,645
Liabilities and Net Assets						
Current liabilities:						
Current portion of long-term debt	$ 296	4	300	76	2	78
Master trust debt classified as short-term	110	—	110	57	—	57
Accounts payable	984	114	1,098	624	60	684
Accrued compensation	1,109	93	1,202	1,033	78	1,111
Other current liabilities	1,188	647	1,835	1,623	668	2,291
Total current liabilities	3,687	858	4,545	3,413	808	4,221
Long-term debt, net of current portion	6,126	132	6,258	6,457	28	6,485
Pension benefit obligation	1,065	—	1,065	1,054	—	1,054
Other liabilities	484	686	1,170	509	630	1,139
Total liabilities	11,362	1,676	13,038	11,433	1,466	12,899
Net assets:						
Net assets without donor restrictions	11,739	1,417	13,156	12,178	1,367	13,545
Net assets with donor restrictions	827	408	1,235	761	440	1,201
Total net assets	12,566	1,825	14,391	12,939	1,807	14,746
Total liabilities and net assets	$ 23,928	3,501	27,429	24,372	3,273	27,645

See accompanying independent auditors' report

PROVIDENCE ST. JOSEPH HEALTH

Supplemental Schedule – Obligated Group Combining Statements of Operations Information

Years ended December 31, 2018 and 2017

(In millions of dollars)

	2018			2017		
	Obligated Group	Nonobligated, eliminations, Other	Total combined	Obligated Group	Nonobligated, eliminations, Other	Total combined
Operating revenues:						
Net patient service revenues	$ 18,439	670	19,109	17,630	506	18,136
Provision for bad debts	(111)	—	(111)	(243)	(26)	(269)
Net patient service revenues less provision for bad debts	18,328	670	18,998	17,387	480	17,867
Other revenues	1,768	3,662	5,430	1,844	3,452	5,296
Total operating revenues	20,096	4,332	24,428	19,231	3,932	23,163
Operating expenses:						
Salaries and benefits	10,643	1,240	11,883	10,391	1,073	11,464
Supplies	3,311	252	3,563	3,194	196	3,390
Interest, depreciation, and amortization	1,273	87	1,360	1,232	75	1,307
Purchased services, professional fees, and other	4,102	3,355	7,457	3,827	3,172	6,999
Total operating expenses before restructuring costs	19,329	4,934	24,263	18,644	4,516	23,160
Excess of revenue over expenses from operations before restructuring costs	767	(602)	165	587	(584)	3
Restructuring costs	162	—	162	—	—	—
Excess (deficit) of revenues over expenses from operations	605	(602)	3	587	(584)	3
Net nonoperating (losses) gains:						
Loss on extinguishment of debt	(6)	—	(6)	—	—	—
Investment (loss) income, net	(330)	(36)	(366)	773	109	882
Other	(87)	11	(76)	(4)	(101)	(105)
Total net nonoperating (losses) gains	(423)	(25)	(448)	769	8	777
(Deficit) excess of revenues over expenses	$ 182	(627)	(445)	1,356	(576)	780

See accompanying independent auditors' report.

Exhibit 23
Employee Training and Development Policy

Origination:	*10/1995*
Effective:	*03/2018*
Last Approved:	*03/2018*
Last Revised:	*03/2018*
Next Review:	*03/2020*
Owner:	*Michael Gustafson: Quality Analyst*
Area:	*Human Resources*
References:	
Applicability:	*Providence OR - Home Services*

Employee Training and Development HS 700-8

ROVIDENCE HOME SERVICES**POLICY/PROCEDURE 700-8**

Management of Human ResourcesOperational

Effective: 10/95

Revised\Reviewed: 10/2017

SUBJECT:Employee Training and Development

SUMMARY OF CHANGES: Minor edits completed.

I.OBJECTIVE

Provide a process for the development and review of unit/department annual and initiative driven competencies. (For Hospice Volunteer staff, see HO 306-17 Volunteer Program policy).

II.POLICY

A. Staff responsible for providing direct patient care will have experience, training, licensure or certification as outlined in their job descriptions and as appropriate to their assigned responsibilities.

B. Initial and recurring competency assessments may include direct observation, testing, certification, documented completion of e-learnings, and documented attendance at in-servicest as required by the duty and position. Competency validation will be completed by someone who is appropriately qualified through experience, knowledge, or education.

C. Managers and Supervisors responsible for patient care services have appropriate training and current state licensure for the services supervised as outlined in their job descriptions.

D. Consultation with a qualified individual within Home Services or in the Health System will occur whenever staff/supervisor does not have appropriate training or experience within their scope of services.

E. All new employees are oriented to the organization and their responsibilities through participation in and orientation to the Region, Home Services Division, and individual departments.

G.Home Services Orientation includes the following topics for employees:

1. Discussion of the history, mission and organizational structure of Home Services.
2. Overview of the scope of service and job responsibilities within each department.
3. Discussion of Shared Services: Education/Infection Prevention; Quality Management: quality monitors,

risk management, customer concerns, and unusual occurrences.

4. Discussion of shared care concerns: how to recognize and process ethical issues, screening for abuse and neglect, conflict of Interest, professional boundaries, patient rights and responsibilities, with specific reinforcement of confidentiality, HIPAA and the Integrity Program.

H.Departmental orientation includes at least the following for employees:

1. Introduction to team members and their roles.
2. Tour of department and work area.
3. Review of job responsibilities and duties, including responsibilities related to safety and infection control.
4. Review of performance standards including telephone, attendance and appearance.
5. Review of departmental organizational structure.
6. Discussion of appropriate policies and procedures, including safety and infection control as related to job functions.
7. How to access policies, benefits and critical information on the Providence Intranet or an alternative method according to their job functions.
8. Review of HIPAA, confidentiality, and security measures for patient information.
9. Discussion of work practices, meals, breaks, schedule, time cards, salary, performance appraisals, vacations, absences, unusual occurrence reports, etc.
10. Issue of facility property as appropriate, e.g. keys, equipment, tools, supplies.
11. Safe and appropriate use of equipment in the workplace.
12. Mandatory safety in-services, i.e., environment of care and injury prevention.
13. Software training appropriate to their job functions.
14. Emergency Management, safety and evacuation procedures specific to the job and work center.

I. All clinical staff orientation includes the additional topics as appropriate to the scope of their job responsibilities.

1. Types of service to be delivered in the patient's environment.
2. Coordination of patient services within and between departments.
3. Safe and appropriate use of equipment in the home.
4. Home Safety, including bathroom, fire, environmental and electrical as well as safety issues for services provided including fire prevention and security.
5. Personal safety in the home and community during home visits.

1. Securing sensitive data during offsite patient care and service.
2. Storage, handling and access to supplies, medical gases, and drugs
3. Identification, safe handling and disposal of infectious/hazardous wastes or materials
4. Bloodborne Pathogens
5. Community Resources
6. Guidelines for appropriate and timely referrals

7. Review of Advance Directives and death and dying
8. Screening for Abuse and Neglect
9. Psychosocial and spiritual issues related to death and dying
10. Appropriate communication skills.
11. Appropriate clinical judgment skills
12. Grief and Bereavement
13. Pain and symptom control
14. Death in the home
15. Emotional support for staff

A. Initial Competency Assessments (refer to paragraph II.B) may include a Pre-Training Self-Assessment that is completed upon hire and is used by the supervisor and employee in planning orientation.

1. Initial Competency Assessments are based on job functions, care and services provided, ages and types of populations served and are completed during the Trial Service Period.
2. Assessments are completed by supervisors or experienced designees.
3. In addition, nurses complete a baseline Performance Based Development System (PBDS) competency assessment to evaluate critical thinking and interpersonal communication skills.

K.All new employees are evaluated during their Trial Service Period according to Regional Human Resources Policy.

L.The qualification, orientation, and competency evaluation for Home Health Aides is outlined in the HS Home Health Aide Services policy (refer to paragraph II.B).

M.Performance evaluations for staff are based on job descriptions and documented and reviewed annually according to Regional Human Resources Policy. They provide opportunities for staff to discuss their job performance and competency with their supervisors and set goals for the upcoming year. Salary increases are directly related to the employee's performance and/or bargaining unit agreements.

N.Employees are informed in a timely manner of new and revised policies / procedures that pertain to their job or job responsibilities through staff meetings, in-services, or by receiving access to or actual copies of the policy / procedure.

O.Ongoing Competency Assessments are determined by duty and position (refer to paragraph II.B) and required timeframes. Competencies are reviewed and revised at least every three years by each department, as well as the HS Nursing Education Committee and HS Healthstream Education Committee taking into consideration new products and services, technical skills as influenced by staff learning needs assessments, performance evaluations, performance improvement data or other operational data sources.

P.An annual supervisory home visit is made with all care staff to observe and evaluate clinical competency in the home. Additional supervisory visits are scheduled at the discretion of the supervisor.

Q.Employees are required to annually complete the Environment of Care topics as assigned by the Oregon Region. Topics include: general safety, hazardous materials, emergency preparedness, fire safety, safe medical equipment (as applicable), workplace violence, and infection prevention.

R.All clinical staff are required to complete annual Bloodborne Pathogen training.

S.In addition to the above reviews, clinical staff that provide service in the home are required to obtain training every other year in age related competencies. Clinical staff also need to maintain a current Basic Life Support (BLS) certification from the following authorized governing bodies: American Heart Association (AHA) –BLS Provider, American Red Cross (ARC)- BLS for Healthcare Provider, or Military Training Network (MTN)- Healthcare Provider.

T.All care staff receives instruction on Advanced Directives in accordance to policy.

UStaff development is based on analysis of staff identified needs and trends, in addition to individual staff feedback regarding the content, value and applicability of in-services.

V.Staff are encouraged to attend ongoing in-service and continuing educational programs provided by the departments, Home Services, other Providence Health & Services of Oregon, and outside of the organization as appropriate to their patient care or service responsibilities and the maintenance of skills needed for service provided.

W.Time off and expenses for continuing education will be allowed in accordance with existing Providence Health & Services of Oregon education, training and leave policies.

X.In-service and continuing education attendance records are to be sent to the Healthstream Administrator for data entry into HealthStream.

Y.Employees providing patient care are responsible for maintaining and tracking their current individual continuing education attendance.

Z. Documents demonstrating orientation, and competency validation will be kept and maintained at the department level. Healthstream Transcripts may be printed as needed to demonstrate the completion of required training.

III.REFERENCES

A.Regional Human Resources Policies and Procedures

1.HR #303 Introductory Period

2. HR # 301 Employment

3.HR #504 Tuition Reimbursement

4.HR #602 Performance Appraisals

5.HR #708 Employee Education

6.HR # 707 Licenses and Certifications

B.Home Services Policies

1. HS 1000-1 Advanced Directives

2.HO 306-17 Volunteer Program

1. HS 301-1 Home Health Aide Services
2. HS 800-14 Securing Sensitive Patient Data during Offsite Patient Care

Attachments:

No Attachments

Approval Signatures

Approver	Date
Michael Gustafson: Quality Analyst	03/2018

Applicability

OR - Clinical Support Staff (CSS), OR - Connections, OR - Credena Health (CH), OR - Home Health (HH), OR - Home Medical Equipment (HME), OR - Home Services, OR - Home Services Pharmacy (HSRx), OR - Hospice (HO)

Exhibit 24
Home Health & Hospice Aide Education, 2019

Home Health and Hospice Aide Education for 2019

Topic	Date	Facilitator/Instructor	Location
East : Guest Speaker OT Cedar Hills: Humor in Healing	1/16/2019	East: Sara Rabuck OT Cedar Hills: Sasha	Live at Cedar Hills and East (Halsey Steel Conference Room)
Ethics in Home Services And when to call APS	2/20/2019	MSW Guest Speakers	Live at Cedar Hills and Live at Halsey-Steel Conference Room
Care Plan and Delegations (Sasha)	3/20/2019	Sasha and Katie	Live at Cedar Hills and Live at Halsey-Broadway Conference Room
Drug Diversion (Sasha)	4/17/2019	Sasha and Katie	Live at Cedar Hills and Live at Halsey-Steel Conference Room
Workplace Violence Situational Awareness (Katie)	5/15/2019	Sasha and Katie	Live at Cedar Hills and Live at Halsey-Steel Conference Room
Ostomy Competency	6/19/2019	WOCN Guest Speakers	Live at Cedar Hills and Live at Halsey-Broadway Conference Room
Hoarding Households and other complications to home care (Katie)	7/17/2019	Sasha and Katie	Live at Cedar Hills and Live at Halsey-Steel Conference Room
OT Learning East PT Learning West	8/21/2019	Sasha and Katie	Live at Cedar Hills and Live at Halsey-Steel Conference Room
OT Learning West PT Learning East	9/18/2018	Sasha and Katie	Live at Cedar Hills and Live at Halsey-Steel Conference Room
Skills Day Competencies VS, Lifts, Transfers, o2 Safety	10/16/2019	Sasha and Katie	HALSEY only! 3 hours –Halsey QUAD
Influenza Education/TB/ Infection Control	11/20/2019	Twilla	Live at Cedar Hills and Live at Halsey-Steel Conference Room
Make-Up day: Ostomy, Lifts, VS, Transfers, o2 safety	12/18/2019	Sasha and Katie	Halsey-Steel/Hawthorne Conference Rooms

Exhibit 25
Providence Home Services Clinical Ladder Handbook

PROVIDENCE
Home Services

Providence Home Services

Clinical Ladder Handbook

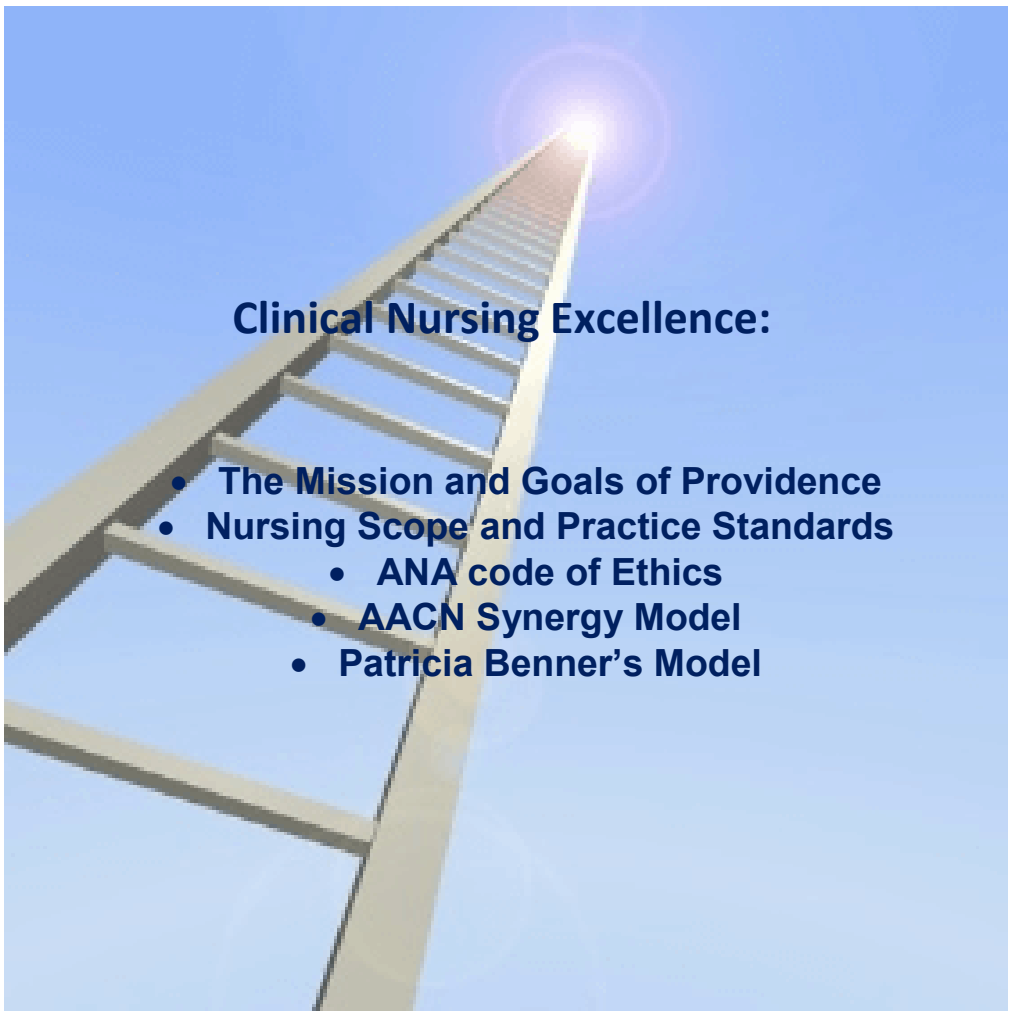


Table of Contents

Introduction

Welcome to the Home Services Clinical Ladder!

As a nursing professional, we know you are committed to achieving clinical and professional excellence as you move through your career. The Providence Home Services Nursing Clinical Ladder Program is an important step in recognizing and rewarding a nurse's professional development, education and experience.

Our goal in producing this manual is to create a one-stop information point for successful completion of the Clinical Ladder process. This document gives an overview of the program with easy-to-follow instructions to encourage you to achieve Clinical Ladder levels. It is highly recommended that you meet with a Clinical Ladder board member in your department during the process of writing your clinical ladder.

We hope you'll find this a useful guide for demonstrating your commitment to the important work we all do.

Sincerely,

The Clinical Ladder Board

Clinical Ladder Overview

What is a Clinical Ladder?

The Providence Clinical Ladder program is a system whereby a nurse can demonstrate and be rewarded for excellence in patient care. The Clinical Ladder program encourages nurses to take the initiative for professional growth and development in their clinical field, thereby enhancing quality of care, patient outcomes and nursing satisfaction. The Clinical Ladder program consists of three levels of proficiency, each of which has different criteria for achievement and carries salary and education benefits. It is up to each individual nurse to apply for the Clinical Ladder designation.

Who is eligible for Home Services Clinical Ladder?

Eligible nurses are those in Providence Home Services who feel they have achieved a high level of professionalism in patient care and are ready to earn the benefits and rewards of this professional development program.

To be eligible the applicant:

- Is a non-exempt staff nurse providing patient care
- Has not received a written Correction Action for one year prior to the application date
- Does not have any unresolved written warnings
- Is practicing at an advanced level as demonstrated on the Benner Scale
- Obtains Supervisor's signature verifying the above criteria

How do I participate in the Clinical Ladder program?

The applicant is required to select a coach to work with in completing the initial Clinical Ladder application. Clinical Ladder Board members are available as coaches to support or assist you as you work through the criteria and application process. Applicants should read this handbook, work with their coach and begin on their exemplars for the level they select. The exemplar is a narrative describing steps taken and lessons learned to prove mastery of Clinical Ladder levels.

What are the elements that are measured in the Clinical Ladder program?

- Education
- Caring Practice and Case Management
- Clinical Knowledge and Decision Making
- Collaboration and Teamwork

What are the levels of the Clinical Ladder program?

There are four levels of achievement for the Clinical Ladder program. After eligibility has been granted, the level status is good for two years with an annual maintenance application. (Please note: These levels do not have to be taken in order. A nurse can apply to the program at any level.) Work with your coach to determine which levels are appropriate for you.

Clinical Ladder Level 1 *(Currently no financial compensation per ONA contract.)*

Education

Complete 1-2.

- ❑ 1. List and provide proof of completion of **20** contact hours that you have earned in the past 24 months.
- ❑ 2. Give **one** example of how you applied this education to your practice.

Caring Practice

Complete 1-3. Demonstrate by exemplar how you:

- ❑ 1. Actively incorporated input from patients and families into the plan of care.
- ❑ 2. Advocated for patients or self, utilizing appropriate resources.
- ❑ 3. Anticipated, assessed, and addressed patient/family learning needs.

Clinical Knowledge and Decision-Making

Complete 1-2. Demonstrate by exemplar how you:

- ❑ 1. Articulated rationale for clinical decisions. (Provide rationale for interventions based on patient diagnosis and expected course of illness. Include expectations in evaluation based on knowledge of patient population and indicate plan for revisions to care plan as patient's illness progressed or improved.)
- ❑ 2. Read one evidence-based or research article, published within the last 5 years and peer reviewed.
  - o Provide summary analysis of data and findings
  - o Review how the article relates to current practice
  - o Document how you shared findings with peers using any of the following methods: poster board, staff meeting, email, newsletter, or informal sharing
  - o **Include Article in submission**

*In addition: Select at least **two** bullet points from the options below. Include documentation with dates.*

- ❑ Shared key points of education from conferences by using **two** of any of the following methods: poster board, staff meeting, newsletter, email, or informal sharing. Include date, topic, and persons receiving education.
- ❑ *Actively working on or have obtained a Bachelor degree or higher in nursing in the last 2 years.
- ❑ Certification in a specialty area of nursing that is recognized by Home Health Services.
- ❑ *Worked on a department-specific project with approval of supervisor or manager. Describe the project including amount of time spent on it and how it contributes to the department.
- ❑ *Acted as preceptor for new staff or student. (Excludes single day experiences.) Identify whether new staff or student & length of preceptorship.
- ❑ *Provided health care related community service. Define length and type of service.
- ❑ *Acted as Clinical Instructor in nursing. Define hour's provided and educational setting.

*For these items you can provide two examples in lieu of an additional bullet.

Collaboration and Teamwork

Demonstrate by exemplar how you:

- ❑ Modeled teamwork and core values utilizing the Healthy Work Environment Initiative principles. Provide details using **two** or more of the standards outlined in this binder.

Clinical Ladder Level 2

Education

Complete 1-3.

- ❑ 1. List and provide proof of completion of **25** contact hours (CE) hours that you have earned in the past 24 months.
- ❑ 2. Give **two** examples of how you applied this education to your practice.
- ❑ 3. Provide certificate of completion or proof of attending one ethics-based program/educational in-service (this may be obtained through on-line learning).
  - o Write up a summary of what was learned.
  - o Document how you shared findings with peers using any of the following methods: poster board, staff meeting, email, newsletter, or informal sharing.

Caring Practice

Complete 1-4. Demonstrate by exemplar how you:

- ❑ 1. Actively incorporated input from patients and families into the plan of care.
- ❑ 2. Advocated for patients or self, utilizing appropriate resources.
- ❑ 3. Anticipated, assessed, and addressed patient/family learning needs.
- ❑ 4. Developed a complex plan of care and how you incorporated anticipated outcomes.

Clinical Knowledge and Decision-Making

Complete 1-3. Demonstrate by exemplar how you:

- ❑ 1. Articulated rationale for clinical decisions. (Provide rationale for interventions based on patient diagnosis and expected course of illness. Include expectations in evaluation based on knowledge of patient population and indicate plan for revisions to care plan as patient's illness progressed or improved.)
- ❑ 2. Read one Evidence-Based or research article, published within the last 5 years and peer reviewed.
  - o Provide summary analysis of data and findings
  - o Review how the article relates to current practice
  - o Document how you shared findings with peers using any of the following methods: poster board, staff meeting, email, newsletter, or informal sharing
  - o **Include Article in submission**
- ❑ 3. Taught co-workers the rationale for clinical decisions.

*In addition: Select at least **three** bullet points from the options below. Include documentation with dates.*

- ❑ Shared key points of education from conferences by using **two** of any of the following methods: poster board, staff meeting, newsletter, email, or informal sharing. Include date, topic, and persons receiving education.
- ❑ *Actively working on or have obtained a Bachelor degree or higher in nursing in the last 2 years.
- ❑ Certification in a specialty area of nursing that is recognized by Home Health Services.
- ❑ *Worked on a department-specific project with approval of supervisor or manager. Describe the project including amount of time spent on it and how it contributes to the department.

- ❑ *Acted as preceptor for new staff or student. (Excludes single day experiences.) Identify whether new staff or student & length of preceptorship.
- ❑ *Provided health care related community service. Define length and type of service.
- ❑ *Acted as Clinical Instructor in nursing. Define hours provided and educational setting.
- ❑ *Wrote and presented to peers a case study that documented an unexpected reaction to a therapeutic regimen for a specific patient situation. Include copy of case study and sign-in sheet for presentation.

- ❑ *Project work.

  Took an active leadership role to improve patient outcome, consistent with departmental goals and grounded in evidence-based practice or research. Include leadership, name(s) of Project, the Project Partners, and Participants
  - Brief Summary or Abstract.
  - Evidence Table.
  - Project Goals and Objectives.
  - Describes the new process or intervention.
  - Describe how the process was implemented.
  - Describe the outcome and evaluate if the process change impacted the baseline metric.
  - Describe how the information was disseminated.
  - Summary. Describe the impact of the project on unit/departmental goals and significance to practice.

  (Projects that require more than one year to complete should include documentation on progress and maintenance, as well as the prior year's project. Include appropriate stakeholders which include the manager or unit educator)

* For this item you can use two examples in lieu of an additional bullet.

Collaboration and teamwork

Complete 1-2. Demonstrate by exemplar how you:

- ❑ 1. Modeled teamwork and core values utilizing the Healthy Work Environment Initiative principles. Provide details using **two-** or more of the standards outlined in this binder.
- ❑ 2. Had an active role in Providence Mission and Vision education and/or practice. Describe the project including amount of time spent on it and how it contributed to the Mission.

*In addition: Select at least **two** bullet points from the options below. Include documentation with dates.*

- ❑ *Mentored at least one other clinician in reviewing the literature for application to Clinical Ladder. Supply name and dates. Include copy of Ladder application form with manager/direct supervisor approval of intended applicant.
- ❑ * Participated in department-specific CQI work, include type and findings and how findings shared with peers.
- ❑ * Sought out improvements within the department that directly relate to improving outcomes. This

may include work done as part of a work-team or committee. Include documentation of the process.

- ❑ *Acted in a consultant role regarding patient care issues for another medical profession (MD/LPN/RN/) or outside facility.
- ❑ *Participated as a member of a department or regional committee, task force, or work team addressing current issues. Participation must be for at least 6 months. Include meeting minutes to document your participation.
- ❑ *Involved with the professional organization related to your specialty: OAHC, OHA, ONA, INS, or WOCN. Include dates and explanation of your involvement (for example: meeting attendance, presentations you made, committee work, etc.).
- ❑ *Recognized an ethical patient care issue and collaborated with the appropriate discipline to resolve the issue. Included write-up of issue with dates, names of those who collaborated, and outcome of issue.

*For these items you can provide two examples in lieu of an additional bullet.

Clinical Ladder Level 3

Education

Complete 1-3.

- ❑ 1. List and provide proof of completion of **30** contact hours that you have earned in the past 24 months.
- ❑ 2. Give **three** examples of how you applied this education to your practice.
- ❑ 3. Provide certificate of completion or proof of attending one ethics-based program/educational in-service (this may be obtained through on-line learning).
  - o Write up a summary of what was learned.
  - o Document how you shared findings with peers using any of the following methods: poster board, staff meeting, email, newsletter, or informal sharing.

Caring Practice

Complete 1-5. Demonstrate by exemplar how you:

- ❑ 1. Actively incorporated input from patients and families into the plan of care.
- ❑ 2. Advocated for patients or self, utilizing appropriate resources.
- ❑ 3. Anticipated, assessed, and addressed patient/family learning needs.
- ❑ 4. Developed a complex plan of care and how you incorporated anticipated outcomes.
- ❑ 5. Acted as an expert or resource for peers/co-workers to guide clinical decision-making. (Include dates.)

Clinical Knowledge and Decision-Making

Complete 1-4. Demonstrate by exemplar how you:

- ❑ 1. Articulated rationale for clinical decisions. (Provide rationale for interventions based on patient diagnosis and expected course of illness. Include expectations in evaluation based on knowledge of patient population and indicate plan for revisions to care plan as patient's illness progressed or improved.)
- ❑ 2. Read one Evidence-Based or research article, published within the last 5 years and peer reviewed.
  - o Provide summary analysis of data and findings
  - o Review how the article relates to current practice
  - o Document how you shared findings with peers using any of the following methods: poster board, staff meeting, email, newsletter, or informal sharing
  - o **Include Article in submission**
- ❑ 3. Taught co-workers the rationale for clinical decisions.
- ❑ 4. Mentored and coached fellow staff. Review how you gave meaningful and constructive feedback.

*In addition: Select at least **four** bullet points from the options below. Include documentation with dates.*

- ❑ *Identified learning needs of the department and facilitated staff education at the department level. May include working with a manager or educator. Note date, topic and person(s) receiving the education update. Identify how the information was shared (poster board, staff meeting,

newsletter, email or information sharing).

- ❑ *Actively working on or have obtained a Bachelor degree or higher in nursing in the last 2 years.
- ❑ Certification in a specialty area of nursing that is recognized by Home Health Services.
- ❑ *Acted as preceptor for new staff or student. (Excludes single day experiences.) Identify whether new staff or student & length of preceptorship.
- ❑ * Provided health care related community service. Define length and type of service.
- ❑ *Acted as Clinical Instructor in nursing. Define hours provided and educational setting.
- ❑ *Wrote and presented to peers a case study that documented an unexpected reaction to a therapeutic regimen for a specific patient situation. Include copy of case study and sign-in sheet for presentation.

- ❑ *Project work.

  Took an active leadership role to improve patient outcome, consistent with departmental goals and grounded in evidence-based practice or research. Include appropriate stakeholders which include the CNS, manager or unit educator.
  - Name(s) of Project, the Project Partners, and Participants.
  - Brief Summary or Abstract.
  - Evidence Table.
  - Project Goals and Objectives.
  - Describes the new process or intervention.
  - Describe how the process was implemented.
  - Describe the outcome and evaluate if the process change impacted the baseline metric.
  - Describe how the information was disseminated.
  - Summary. Describe the impact of the project on unit/departmental goals and significance to practice.

  (Projects that require more than one year to complete should include documentation on progress and maintenance, as well as the prior year's project. Include appropriate stakeholders which include the manager or unit educator.)

*For these items you can provide two examples in lieu of an additional bullet.

Collaboration and teamwork

Complete 1-2. Demonstrate how you:

- ❑ 1. Modeled teamwork and core values utilizing the Healthy Work Environment Initiative principles. Provide details using **three** or more of the standards outlined in this binder.
- ❑ 2. Had an active role in Providence Mission and Vision education and/or practice. Describe the project including amount of time spent on it and how it contributed to the Mission.

*In addition: Select at least **three** bullet points from the options below. Include documentation with dates.*

- ❑ *Mentored at least one other clinician in reviewing the literature for application to Clinical Ladder. Supply name and dates. Include copy of Ladder application form with manager/direct supervisor approval of intended applicant.
- ❑ * Participated in department-specific CQI work, include type and findings and how findings shared with peers.
- ❑ * Sought out improvements within the department that directly relate to improving outcomes. This may include work done as part of a work-team or committee. Include documentation of the process.

- ❑ *Acted in a consultant role regarding patient care issues for another medical profession (MD/LPN/RN/) or outside facility.
- ❑ *Participated as a member of a department or regional committee, task force, or work team addressing current issues. Participation must be for at least 6 months. Include meeting minutes to document your participation.
- ❑ *Involved with the professional organization related to your specialty: OAHC, OHA, ONA, INS, or WOCN. Include dates and explanation of your involvement (for example: meeting attendance, presentations you made, committee work, etc.).
- ❑ *Recognized an ethical patient care issue and collaborated with the appropriate discipline to resolve the issue. Included write up of issue with dates, names of those who collaborated, and outcome of issue.

*For these items you can use two examples in lieu of an additional bullet.

Clinical Ladder Level 4

Education

Complete 1-4.

- ❑ 1. List and provide proof of completion of **35** contact hours that you have earned in the past 24 months.
- ❑ 2. Give **four** examples of how you applied this education to your practice.
- ❑ 3. Provide Proof of Certification in a specialty area of nursing that is recognized by Home Services.
- ❑ 4. Provide certificate of completion or proof of attending one ethics-based program/educational in-service (this may be obtained through on-line learning).
  - o Write up a summary of what was learned
  - o Document how you shared findings with peers using any of the following methods: poster board, staff meeting, email, newsletter, or informal sharing

Caring Practice

Complete 1-5. Demonstrate by exemplar how you:

- ❑ 1. Actively incorporated input from patients and families into the plan of care.
- ❑ 2. Advocated for patients or self, utilizing appropriate resources.
- ❑ 3. Anticipated, assessed, and addressed patient/family learning needs.
- ❑ 4. Developed a complex plan of care and how you incorporated anticipated outcomes.
- ❑ 5. Acted as an expert or resource for peers/co-workers to guide clinical decision-making. (Include dates.)

Clinical Knowledge and Decision-Making

Complete 1-5. Demonstrate by exemplar how you:

- ❑ 1. Articulated rationale for clinical decisions. (Provide rationale for interventions based on patient diagnosis and expected course of illness. Include expectations in evaluation based on knowledge of patient population and indicate plan for revisions to care plan as patient's illness progressed or improved.)
- ❑ 2. Read one Evidence-Based or research article, published within the last 5 years and peer reviewed.
  - o Provide summary analysis of data and findings
  - o Review how the article relates to current practice
  - o Document how you shared findings with peers using any of the following methods: poster board, staff meeting, email, newsletter, or informal sharing
  - o **Include Article in submission**
- ❑ 3. Taught co-workers the rationale for clinical decisions.
- ❑ 4. Mentored and coached fellow staff. Review how you gave meaningful and constructive feedback.
- ❑ 5. Were recognized as a clinical expert in specialty and utilized by the interdisciplinary team to improve patient care. (Provide an example and include dates.)

*In addition: Select at least **five** bullet points from the options below. Include documentation with dates in your exemplar.*

- ❑ *Identified learning needs of the department and facilitated staff education at the department level. May include working with a manager or educator. Note date, topic and person(s) receiving the education update. Identify how the information was shared (poster board, staff meeting, newsletter, email or information sharing).
- ❑ *Actively working on or have obtained a Bachelor degree or higher in nursing in the last 2 years.
- ❑ *Acted as preceptor for new staff or student. (Excludes single day experiences) Identify whether new staff or student & length of preceptorship.
- ❑ *Provided health care related community service. Define length and type of service.
- ❑ *Acted as Clinical Instructor in nursing. Identify hours provided and educational setting.
- ❑ *Wrote and presented to peers a case study that documented an unexpected reaction to a therapeutic regimen for a specific patient situation. Include copy of case study and sign-in sheet for presentation.
- ❑ *Project work.

  Took an active leadership role in evidence-based practice or research projects to improve patient outcomes consistent with unit/departmental or system goals. Include appropriate stakeholders which include the CNS, manager or unit educator.
  - Name(s) of Project, the Project Partners, and Participants.
  - Brief Summary or Abstract.
  - Evidence Table.
  - Project Goals and Objectives.
  - Describes the new process or intervention.
  - Describe how the process was implemented.
  - Describe the outcome and evaluate if the process change impacted the baseline metric.
  - Describe how the information was disseminated.
  - Summary. Describe the impact of the project on unit/departmental goals and significance to practice.

  (Projects that require more than one year to complete should include documentation on progress and maintenance, as well as the prior year's project. Include appropriate stakeholders which include the manager or unit educator.)
- ❑ *Performed a meta-analysis of an intervention or topic pertinent to~~, or in support of,~~ Home Services. Describe the review of the research, types of research and findings of the research. Document the communication of your findings with colleagues.
- ❑ *Wrote and contributed healthcare-related articles to professional newsletters or other publications.

*For these items you can provide two examples in lieu of an additional bullet.

<u>Collaboration and Teamwork</u>

Complete 1-2. Demonstrate how you:

- ❑ 1. Modeled teamwork and core values utilizing the Healthy Work Environment Initiative principles. Provide details using **four** or more of the standards outlined in this binder.
- ❑ 2. Had an active role in Providence Mission and Vision education and/or practice. Describe the project including amount of time spent on it and how it contributed to the Mission.

*In addition: Select at least **four** bullet points from the options below. Include documentation with dates.*

- ❑ *Mentored at least one other clinician in reviewing the literature for application to Clinical Ladder. Supply name and dates. Include copy of Ladder application form with manager/direct supervisor approval of intended applicant.
- ❑ *Participated in department-specific CQI work, include type and findings and how findings shared with peers.
- ❑ *Sought out improvements within the department that directly relate to improving outcomes. This may include work done as part of a work-team or committee. Include documentation of the process.
- ❑ *Acted in a consultant role regarding patient care issues for another medical profession (MD/LPN/RN/) or outside facility.
- ❑ *Participated as a member of a department or regional committee, task force, or work team addressing current issues. Participation must be for at least 6 months. Include meeting minutes to document your participation.
- ❑ *Involved with the professional organization related to your specialty: OAHC, OHA, ONA, INS, or WOCN. Include dates and explanation of your involvement (for example: meeting attendance, presentations you made, committee work, etc.).
- ❑ *Recognized an ethical patient care issue and collaborated with the appropriate discipline to resolve the issue. Included write up of issue with dates, names of those who collaborated, and outcome of issue.

*For these items you can provide two examples in lieu of an additional bullet.

Continuous Expert Level 4

Once completing three full cycles (3 full ladder applications and 3 maintenance forms) at Expert level (Clinical Ladder Level 4), an applicant may submit a Continuous Expert Level 4 packet **annually**.

A Continuous Expert Level 4 packet includes the following:

1. Current level of practice documented by Supervisor or Manager on the Benner Scale.
2. Clinical Ladder application signed by Supervisor or Manager.
3. Proof of current Certification in a specialty area of nursing that is recognized by Home Services.
4. Proof of **18** contact hours earned in the previous **12** months.
5. An exemplar demonstrating the following:
    - Work on a department project, approved by the Manager, where you have identified an opportunity for the department or for patient care.
    - Presentation of this project to the department, which includes identified practice change and staff education to achieve this change. Collaborate with department Educator in the development of this presentation.

An applicant may continue at **Continuous Expert Level 4** annually unless the following occurs:

- They change specialty. In this case, they must submit a full portfolio for the purpose of verifying their attainment of expertise in the new specialty. Once verified, they can return to Continuous Expert Level packet submissions.
- They let their Certification lapse.

Appendix A

AACN Healthy Work Environment Initiative: 6 Essential Standards

The creation of healthy work environments is imperative to ensure patient safety, enhance staff recruitment and retention, and maintain an organization's financial viability. They support the idea to deliver patient-centered care as members of an interdisciplinary team, utilizing evidence-based practice, quality improvement approaches, and informatics. These standards support the nine provisions of the American Nurses Association Code of Ethics for Nurses and provide a framework to assist nurses in upholding their obligation to practice in ways consistent with appropriate ethical behavior.

The standards are designed to be used as a foundation for thoughtful reflection and engaged dialogue about the current realities of each work environment. The standards for establishing and sustaining healthy work environments are:

- Skilled Communication
  Nurses must be as proficient in communication skills as they are in clinical skills.

- True Collaboration
  Nurses must be relentless in pursuing and fostering true collaboration.

- Effective Decision Making
  Nurses must be valued and committed partners in making policy, directing and evaluating clinical care and leading organizational operations.

- Appropriate Staffing
  Staffing must ensure the effective match between patient needs and nurse competencies.

- Meaningful Recognition
  Nurses must be recognized and must recognize others for the value each brings to the work of the organization.

- Authentic Leadership
  Nurse leaders must fully embrace the imperative of a healthy work environment, authentically live it and engage others in its achievement.

For more information regarding the AACN Standards for Establishing and Sustaining Health Work Environments please check:
http://www.aacn.org/WD/HWE/Docs/HWEStandards.pdf

Appendix B

Formal Review Process for Clinical Ladder Levels

Completed portfolios must be submitted to the Home Services (HS) Education Manager or a Clinical Ladder Board Member **on or before** the posted due date. Portfolios will be reviewed by at least two Board members, with one from the same discipline as the applicant. If the reviewers do not agree, the Board will be consulted and consensus obtained. The Board's decision will be final and binding.

Please note:

- Level achievement will be denied if criteria are not met.
- If the clinician does not qualify for the level applied for, but meets the level below it, the clinician will be appointed to the lower level.
- At time of Board review, a verbal confirmation of approval or denial for advancement will be made.

If denied, the clinician may resubmit the portfolio (with the recommended changes) to the assigned Board member within 14 days. When the final approval is made, the Home Services Education Manager will be notified.

Minutes of all board proceedings and decisions will be maintained by the Clinical Ladder Chair, HS Education Manager, and/or Management Support Staff.

Recognition

Paperwork for a pay change (Employee Action Notice and CL Board Letter) and Clinical Ladder designation, when approved, will be completed by the HS Manager Education/Infection Prevention and sent to Human Resources where a copy is maintained in the employee file. The clinician is to receive the pay increase within 30 days of Board action date. Pay change will be retroactive to the beginning of the pay period that begins following Board action.

Annual Maintenance

The Application / Annual Maintenance Form will be completed by the participants' supervisor and returned by the next Clinical Ladder Board Review date. Clinicians will be notified of the Board decision within seven working days of Board review. Clinicians who fail to meet stated requirements will be denied continued participation in advanced level, with return to staff RN status and pay rate. Reapplication may occur after full eligibility is achieved.

Renewal

You must complete a new portfolio every two years to keep your Clinical Ladder Level status and benefits. This complete portfolio will include a letter addressing what you have learned from being part of the Clinical Ladder and how your patients have benefited.

Process for Ladder Advancement

Any Clinical Ladder participant who wishes to advance to the next level may either:

- Submit a new portfolio applying to the next level at the point their current level expires.
  OR
- Submit an updated portfolio (demonstrating the next level accomplishments) within the first year of achieving ladder status.

All information submitted must be current (within the last 24 months). A new Ladder expiration date will be established based on the review date for the new level. An updated portfolio will not be accepted during the Maintenance Year (second year) of ladder status, at which point the clinician will be working on a new portfolio.

Transfer Process

Employees who transfer into Providence Home Services and are currently on the Providence Portland Medical Center or Providence St. Vincent Clinical Ladder will be allowed to maintain their ladder status and pay/benefit differential until its expiration date only if the experience used to obtain this status is applicable to their current position.

When ladder status has expired, transferee will need to apply to the Providence Home Services Clinical Ladder program using experience obtained while in the Home Services position.

It is at the discretion of the hiring manager to determine if the experience used to obtain Clinical Ladder status is applicable for their Home Services position.

Appendix C

Writing Exemplars

What is an Exemplar?

An exemplar is a written account of a nurse's interaction with a patient, peer or department where the nurse has learned an important lesson or made a significant contribution that resulted in improvement in patient care and/or processes. The exemplar is the nurse's own written narrative of an experience that made a difference to the patient, the family or the situation.

Exemplars include:

- A brief background or history of the patient/or situation
- A detailed description of what happened
- Why the situation is critical or significant
- What your concerns were
- What you were thinking as things took place
- What stood out to you about the situation?
- Include dates and supportive documentation (emails, CEU's, research articles)

Sample Exemplar for Level 1

The following is a sample exemplar for one of the elements of Clinical Ladder Level One:

Clinical Ladder Level One: Caring Practice

Assessed changing patient needs in complex care situations using a wide range of data collection methods, resources and knowledge of patient populations.

I demonstrated caring practice in a complex medical situation with my patient "Anne" during her care starting in January of 2011. Anne is an 81 year-old female, non-ambulatory and obese, with what was well-controlled DMII and a recent hospitalization for a CHF exacerbation. Anne was stabilized under my care.

The Cardiologist wanted to attempt to diurese the patient further and put the patient on Metolazone. Once this medication was ordered I researched it and found that it can complicate the insulin pathways. I monitored Anne's CBG's closely, along with her water retention.

For the first week Anne did well on this medication and she was diuresing well. I had asked for weekly blood work to monitor her electrolytes with the quick diursesis. The order was approved. I taught the caregivers to watch for signs of muscle weakness, quickly changing blood sugars and rapid weight loss, with symptoms of muscle weakness.

During the third week of Metolazone, Anne's CBG's were becoming erratic. The education that I had given the Assisted Living staff was very beneficial. They called the MD and PCRN when blood sugars were out of control and the patient was feeling weak in the legs. The MD reviewed the recent blood work and found sodium and potassium levels to also be changing and ordered stat potassium and sodium. The levels were critical and the medication was stopped. Medications to lower the potassium were ordered and Anne was under close observation for the next week until her electrolytes and CBG's were again at baseline. The patient will not receive Metolazone again.

If I had not reviewed the medications, trained the staff for symptoms to watch for and ordered weekly chem panels there could have been a different outcome to this situation. There were subtle changes to watch for, and they changed quickly to dramatic changes, but the situation was quickly addressed and the patient was not hospitalized.

Sample Exemplar for Level 2

The following is a sample exemplar for one of the elements of Clinical Ladder Level Two:

Clinical Ladder Level Two: Clinical Knowledge and Decision-Making

Shared Evidence-Based Practice or research from literature with peer group. (Provides summary analysis of data and findings and how it relates to current practice. Use two of any of the following methods: poster board, staff meeting, newsletter, email, or informal sharing. Note date, topic, and person (s) receiving information.)

Evidence Based Article: Effectiveness of a Clinical Ladder Program

Authors: Karen Drenkard, Ellen Swartwout, JONA, 35 (11). pp 502-506

I shared this article with my co-workers during a team meeting on August 9, 2011.

This peer-reviewed article discusses the importance and justifications for an institution to create and incorporate a Clinical Ladder program. A major point made in this article is addressing nurse retention and increasing nurse satisfaction.

This article stresses:

- How lack of recognition for work performance reduces satisfaction
- How Clinical Ladder programs improve staff, patient and physician satisfaction
- Positive outcomes from the Clinical Ladder programs impact the quantity of expert nurses, and health-care expenditures.
- The use of Clinical Ladders indicate decreased costs of nursing staff by reducing nursing sick time, turn-over, and decreased use of agency nurses, as well as higher staff nurse satisfaction.

In summary, the analysis of a Clinical Ladder program in relation to costs, financial impact, and benefits is necessary to justify the salary increments for the ladder programs and provide the nurse executive with appropriate justification and outcome data to effectively champion these programs. This article analyzes the promotion information on a clinical ladder in a five-hospital system from June 2001 to June 2003 and offers areas for consideration that may be helpful to chief nursing officers as they work to create retention strategies. In this program each level of the clinical ladder offered a 6% pay increase for the RN.

How This Relates to Clinical Practice:

Encouragement and increased participation in the Clinical Ladder system can have an overall positive impact on patient outcomes by increasing nurse satisfaction and reducing costs associated with decreased satisfaction.

Sample Exemplar for Level 3

The following are sample exemplars for a few of the elements of Clinical Ladder Level Three:

Clinical Ladder Level Three: Clinical Knowledge and Decision-Making

Is utilized by co-workers as a clinical expert and resource. Give examples of teaching complex assessment skills.

I was asked by management to develop an in-service for the rehab staff on cardiac, bowel, urinary assessment and teaching they could do in the home. There were rehab staff from Yamhill, West side, and East side. See attached handouts and sign in sheets.

Takes a leadership role to actively review, revise, and develops a change in practice to improve pt outcomes. Assists in implementation utilizing formal processes such as the PNCC committee. Document the process and outcomes.

I was asked by my supervisor Susan Allen to develop an in-service for the rehab staff so they could remove staples from joint replacement pts. The appropriate stakeholders in this were the management team and the pts. This decreased costs in that a nurse would not be needed in the pt care team. The PT would be able to remove the staples at a regularly scheduled PT visit. The current practice was for a nurse to make one or even two visits. One as an-add on or admit, then a visit to remove the staples. Yearly I do a competency for the rehab staff. See attached handouts and sign in sheets.

Clinical Ladder Level Three: Collaboration and Teamwork

Seeks out improvements within the department that directly relate to improving outcomes. They may include part of a work-team or committee. Include documentation of the process.

I am on the Clinical Ladder committee and the PNCC committee. I have been committed to the Clinical Ladder. Research shows that pt outcomes improve when an organization has a Clinical Ladder program. The Clinical Ladder program in HH has not been vey successful. I was part of the original ladder and was involved in rewriting the original ladder. The original ladder and the rewrite has not been successful. Now I am on the PNCC committee and involved in a total revamp of the ladder. I have volunteered to be a mentor to help nurses become part of the ladder. See attached emails and meeting minutes.

Sample Exemplar for Level 4

Champions a cause to develop or review a unit specific protocol, procedure, or guideline for clinical accuracy and incorporation of an evidenced based practice. Document the process used to implement change in your unit. For example: supply date of audits, education materials used, evidence of patient outcomes and supportive literature/evidence.

On October 27, 2010 I championed the joining of full time mental health nurses (MHRN) in the Providence Home Health Care Portland system to advocate for lighter patient loads. I initially engendered the support of the three west side nurses and went to Jamie Newman of the Oregon Nurses Association to link us with administration. We wanted to move forward quickly because our supervisor was taking 6 -8 weeks of FMLA. It had been clear to the three MHRNs that this absence would put an undue burden on the existing staff and lead to poor patient outcomes, poor stewardship (more loopas) and increase the wait time for our patients to be seen. Jamie led us to working with the Professional Nursing Care Committee (PNCC) to explore resolving some of those concerns.

To prepare for the PNCC, I completed a retrospective study on the amount of new admissions per clinician as well as the amount of add-ons. I presented my information to the PNCC using a three month time frame indicating clinician work-loads. The presentation included graphs depicting the work load of the different Mental Health clinicians in home health. (Please refer to attached graphs).

In December I began attending the PNCC to begin the process of collaboration to seek solutions. We spent time reviewing my data, typing, and submitting meeting minutes to administration. In the spirit of the PNCC issues should have first been addressed to administration before moving to them for solutions. I spent two meetings presenting over 23 pages of communication between the MHRNs and management in an effort to solve these issues (documentation is available upon request). PNCC meeting minutes are available if needed for this application process. The PNCC summarized the issues presented as follows:

RN caseload expectation is too high. The four Westside behavioral health RNs cover a large territory. The RNs believe that a reasonable caseload would be approximately 25 patients – an upper limit should be 29-30 patients. Agree that behavioral health patients seen by a member of the mental health nursing staff within four weeks of the referral.
We recommend that patients be discharged only when the patient has been adequately prepared for discharge and it is clinically indicated, not when the nursing caseload gets too high.

On 02/09/2011 the PNCC heard concerns from the mental health nurses in regard to issues around large caseloads and staffing. All the members of the PNCC and all the full time mental health nurses from Portland branch agreed to sign a memo requesting concessions to alleviate the issue brought forward. I then was tasked to draft the memo to present to Shaune Mattsson (Director of Home Health) and Shawn Fischer (Human Resource's rep.) Dr. Susan Link and I drafted the memo to present at this meeting. (Please refer to attached copy of memo.)

The results of my initiative and motivation resulted in the following;

- Management would request from Posting Council to post an on-call MH RN position.
- Diane Roberts, MH RN Supervisor would evaluate all the MH RNs' caseload size, with the target of 25 patients per FTE.
- Diane Roberts would assess current available FTE, and request appropriate additional MH RN FTE as needed to maintain the 25 patients/FTE.
- Management would support a trial of the 25 patients/FTE caseload at the West branch.

- Over 3 months, Diane Roberts would track caseload sizes, with the intent to maintain the 25 patients/FTE.
- Diane Roberts would develop a process to review patients at recert.
- Shaune Mattsson would review the “closed to admit” process with key scheduling staff to ensure it is working properly now.
- By February 23, 2011 the on-call position was posted and by April 2011 the position was filled.

Appendix D

Evidence Table Template

Article Title and Author	Date Published	Purpose and Results	Conclusions/Recommendations/ Nursing Implications	Article Limitations

Appendix E

Contact Hour Conversions

CEU Equivalencies:

1 CEU= 10 contact hours
1 contact hour= 0.1 CEU
1 contact hour= 60 minutes
1 academic semester= 15 contact hours
1 academic quarter= 12.5 contact hours

1 CME= 60 minutes or 1 contact hour

Appendix F

Clinical Ladder Board Members

Mary Dehning (Chair)	Home Health
Jenny Lensegrav	Home Health
Cheri Lundin	Home Health
Andrea Marshall	Home Health
Linda Barrera	Home Infusion
Nancy Dobbels	Hospice
Carrie Merrill	Hospice
Erin Olson	Hospice
Twilla Harrington	Leadership Representative (does not review binders)

Exhibit 26
Quality Assessment and Improvement Program

Current Status: *Active*	**PolicyStat ID:** *7094855*

Origination:	*10/2019*
Effective:	*10/2019*
Last Approved:	*10/2019*
Last Revised:	*10/2019*
Next Review:	*10/2021*
Owner:	*Janis Picker: Mgr-qual/Clinical Educ*
Area:	*Administration*
References:	
Applicability:	*OR - Home Health (HH)*

Quality Assurance and Performance Improvement (QAPI), HH 107-3

OBJECTIVE

A. Define the process of how the department establishes and implements an effective quality improvement program that is ongoing, home health wide, and is data driven to ensure:

1. Quality of care and services provided throughout all approved service areas meet or exceed professional standards of care in the home health setting.

2. Participation in the quality reporting process for the Centers of Medicare and Medicaid Services (CMS).

POLICY

A. Providence Home Health QAPI program identifies areas of improvement in patient outcomes, processes of care, home health services, quality of care, patient safety, and non-clinical operations.

B. Improvement opportunities across all home health services are identified and prioritized based on the Mission, Vision, and Strategies of the ministry and measurable outcome data with a focus on safety, clinical excellence, and improved patient experience.

C. Providence Home Health Quality Manager is responsible for facilitating the QAPI program for Providence Home Health.

D. The quality manager along with the Home Health Director, Home Health Managers and Supervisors are responsible for ensuring that home health continues to monitor the quality of service they provide and develop performance improvement projects. Ad hoc work groups will be formed to help research, develop and implement any performance improvement processes.

E. Home Services Leadership Council as delegated by the Governing Body is responsible for the oversight of the QAPI program.

PROCEDURE

A. Key Focus Areas

1. High Risk, high volume or problem- prone areas

2. Patient safety events

3. Patient experience surveys and customer complaints

4. Regulatory requirements related to billing, compliance to standards in documentation and compliance to onboarding, training and competency of staff (employees and contracted)

5. Patient and staff safety related but not limited to infection control

6. Outcome and Assessment Information Set (OASIS) metrics

B. Program Data includes but is not limited to the following sources:

1. Home Health CAHPS (Consumer Assessment of Healthcare Providers System)

2. OASIS measures

3. Home Health Compare

3. Routine and focused chart reviews

4. Unusual occurrence reporting

5. Customer concerns

6. Tracking of infection control issues

7. Reports related but not limited to staff licensing, training, regulatory requirements

C. Process

1. Identify high-risk areas in patient care and department operations.

2. Collect data, review data collected, and analyze the cause.

3. Identify areas of opportunity for improvement including preventive actions.

4. Develop performance plan that is evidenced based practice and patient centered.

5. Provide necessary education regarding the performance improvement plan.

5. Continue to collect data to ensure that improvement is sustained.

6. Re-evaluate/ redesign plans if improvement is not meeting desired outcomes.

7. Continue to educate and to provide staff feedback.

8. Clear expectations for patient safety are established, implemented and maintained.

D. Outcomes

Success of Home Health QAPI program will be measured by achieving and sustaining improvement in scores related to:

1. Selected patient care outcomes, process of care, home health ministry operations or other quality indicators identified as priority goal(s) for the year

2. Patient experience scores/ feedback identified as priority goal(s) for the year

3. Home Health CAHPS survey results

4. Continued participation and meeting or exceeding benchmarks in CMS Quality Reporting program

5. Regulatory compliance as evidenced by state licensure surveys, Medicare Condition of Participation surveys and Joint Commission Accreditation

6. Sentinel event and adverse feedback and learning throughout home health

7. A culture that supports active involvement of leaders and staff in performance improvement initiatives

REFERENCES

A. Governing Body Role HS 100-9

B. Medicare Conditions of Participation Standard 484.65

C. WAC Title 246 Chapter 246-335-555

Attachments:

Approval Signatures

Approver	Date
Janis Picker: Mgr-qual/Clinical Educ	10/2019
Susan Murtha: Exec Dir-Home Hlth	10/2019
Janis Picker: Mgr-qual/Clinical Educ	10/2019
Janis Picker: Mgr-qual/Clinical Educ	10/2019

Applicability

OR - Home Health (HH)

Exhibit 27
OR Provider Credentials
Susan Murtha, Director of Home Health

Verification of Licensure

Oregon State Board of Nursing

17938 SW Upper Boones Ferry Road
Portland, Oregon 97224-7012
Telephone: 971-673-0685
Fax: 971-673-0684
E-Mail: oregon.bn.info@state.or.us

Subject to Terms and Conditions

Information current as of: 10/29/2019
Query Time: 10/29/2019 2:25:30 PM

Return to Search

Print

This site is a primary source for verification credentials.

Licensee: Murtha, Susan Teresa
Gender: Female
City: Gladstone
State: OR

LICENSES

License Number	Type	License Issued	Current Status	Date Last Renewed	License Expiration Date
090000375RN	RN	09/11/1990	Active	02/05/2018	02/20/2020

Click here for explanation of License Status

BOARD ORDERS

No disciplinary actions on record.

Click here for explanation of Order Types

Show License Abbreviation Key

OSBN Discipline - Copies of public documents associated with OSBN disciplinary actions taken against a specific licensee after August 2010 are available online. Copies of disciplinary actions prior to that date may be obtained by written request. You may e-mail your request to osbn.records@state.or.us. Or, you may FAX your request, addressed to Kathleen Simpson, to 971-673-0684. Please include the licensee's name and license number (if available), along with your name, company (if applicable), mailing address, phone number and FAX number or e-mail address.

Exhibit 28
WA Provider Credentials
Nancy Rickerson, Chief of Home Health

Credential Information for: Rickerson Nohavec, Nancy L

Credential	Credential Type	First Issue Date	Last Issue Date	Expiration Date	Credential Status	Enforcement Action
OT00000687	Occupational Therapist License	07/24/1985	07/09/2019	07/28/2021	ACTIVE	No

Inserted from <https://fortress.wa.gov/doh/providercredentialsearch/>

Exhibit 29
Providence Home Health Licensure Surveys

The Joint Commission

December 2, 2019 HCO ID:# 320680

James Arp
Executive Director, Home & Community Services
Providence Health & Services - Oregon
6410 NE Halsey
Portland, Oregon 97213

Dear Mr. Arp:

This letter confirms that The Joint Commission surveyed Providence Health & Services - Oregon on October 29 – November 1, 2019.

Until the findings from this most recent survey are reviewed and a decision is rendered, The Joint Commission continues to consider Providence Health & Services - Oregon accredited based on the results of your previous full survey on October 25 – October 28, 2016. An accreditation decision on your latest survey findings will be made once the 60-day Evidence of Standards Compliance report has been approved by our central office. At that time, your organization's accreditation status will be updated and displayed on our Quality Check report.

If Providence Health & Services - Oregon achieves accreditation, the accreditation status will be effective for 3 years for all services surveyed under the *Home Care Accreditation Manual*.

We understand that the accreditation process can be confusing at times. If I can be of further assistance, please call me directly at (630) 792-5258.

Sincerely,

Elizabeth Kochitty

Elizabeth Kochitty, MHA
Senior Account Executive & Quality Control Specialist
Division of Accreditation & Certification Operations
The Joint Commission

Oregon Health Authority

Health Care Regulation and Quality Improvement
800 NE Oregon Street, Suite 465
Portland, Oregon 97232
971-673-0540
971-673-0556 (Fax)

December 19, 2017

Ms. Susan Murtha
Providence Home Health
6410 NE Halsey Street, Suite 200
Portland, OR 97213

Dear Ms. Murtha:

Based on the findings of the Medicare recertification survey and State relicensing survey, completed on December 14, 2017, it was determined that Providence Home Health was in compliance with the Conditions of Participation for Home Health Agencies and Oregon Administrative Rules for Home Health Agencies. Enclosed is a Statement of Deficiencies report which reflects that no deficiencies were identified. **Please keep this report for your records.**

If you have any questions, please call our office at (971) 673-0540. Thank you for your cooperation.

Sincerely,

T. Stofiel, RN

Teri-Ann Stofiel, RN
Client Care Surveyor
CMS Representative
Oregon Health Authority
Public Health Division
Health Care Regulation and Quality Improvement

Enclosures

If you need this information in an alternate format, please call our office at (971) 673-0540 or TTY (971) 673-0372.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	387048	A. BUILDING _____ B. WING _____	12/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE HOME HEALTH	6410 NE HALSEY STREET, SUITE 200 PORTLAND, OR 97213

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS An unannounced Federal recertification survey was completed at this agency on 12/14/2017. The agency was surveyed for compliance with 42 CFR Conditions of Participation for Home Health Agencies, Part 484. An entrance conference was held with the Home Health Director on 12/11/2017 at 9:30 AM. The purpose of the survey and the survey needs were explained. An opportunity was provided for questions, answers, and comments. Definitions and abbreviations: CFR - Code of Federal Regulations HIM - Health Information Management	G 000		
G9999	FINAL OBSERVATIONS At the completion of the survey on 12/14/2017 an exit conference was held with the Home Health Director, Quality Manager/Education, and HIM Manager. The East branch Manager, 5 East branch supervisors, the West branch Manager, 2 West branch supervisors, the North Coast branch Manager, the Gorge branch Manager, a Gorge branch supervisor, the Yamhill branch Manager, 2 Yamhill branch supervisors and an HIM supervisor attended by phone. The preliminary findings of the survey were explained. An opportunity was provided for questions, answers, and comments. At the time of the survey, the agency was found to be in substantial compliance with the Conditions of Participation for Home Health Agencies. No Federal deficiencies were	G9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	387048	A. BUILDING _____ B. WING _____	12/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE HOME HEALTH	6410 NE HALSEY STREET, SUITE 200 PORTLAND, OR 97213

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G9999	Continued From page 1 identified.	G9999		

Health Care Regulation and Quality Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13-1392	A. BUILDING: _____ B. WING _____	12/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE HOME HEALTH	6410 NE HALSEY STREET, SUITE 200 PORTLAND, OR 97213

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	INITIAL COMMENTS A state relicensure survey was completed at this agency on 12/14/2017. The agency was surveyed for compliance with Oregon Administrative Rule (OAR) Chapter 333, Division 27, Home Health Agencies. An entrance conference was held with the Home Health Director on 12/11/2017 at 9:30 AM. The purpose of the survey and the survey needs were explained. An opportunity was provided for questions, answers, and comments. At the completion of the survey on 12/14/2017 an exit conference was held with the Home Health Director, Quality Manager/Education, and Health Information Management (HIM) Manager. The East branch Manager, 5 East branch supervisors, the West branch Manager, 2 West branch supervisors, the North Coast branch Manager, the Gorge branch Manager, a Gorge branch supervisor, the Yamhill branch Manager, 2 Yamhill branch supervisors and an HIM supervisor attended by phone. The preliminary findings of the survey were explained. An opportunity was provided for questions, answers, and comments. At the time of the survey, the agency was found to be in substantial compliance with the rules. No state deficiencies were identified.	D 000		

STATE OF OREGON
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATE OF WASHINGTON
DEPARTMENT OF HEALTH

March 24, 2016

Shaune CM Mattsson, RN, MBA
Director of Home Health
Providence Home Services
6410 Halsey St., Suite 200
Portland, OR 97213

RE: State Licensing Survey
IHS License #60108399

Dear Ms. Mattsson:

The Department completed a relicensing survey for Washington Administrative Codes (WAC) 246-335, In-Home Services HOME HEALTH regulations. We have received your Plan of Correction for the deficiencies that were cited. Your Plan of Correction is accepted as written. No further reports will be necessary.

Thank you for your cooperation with the survey process.

Sincerely,

Patricia Terry MPA, RN - IHS Surveyor
Washington State Department of Health
Office of Investigation and Inspection

cc: File

State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011452	A. BUILDING: _____ B. WING _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE HOME HEALTH	6410 NE HALSEY STREET, SUITE 200 PORTLAND, OR 97213

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 000	Initial Comments During the onsite re-licensing survey, ending on 02/12/2016 at Providence Health and Services, Portland, OR, Washington State Department of Health survey staff reviewed WAC 246-335 for In-Home Services - HOME HEALTH category. The Department survey staff found Providence Health and Services, IHS License #60108399, in substantial compliance with the exception of the deficiencies described on the following pages. The survey was conducted by Patricia Terry MPA, RN	Z 000	A Plan of Correction (POC) is due no later than 03/17/2016. The POC can either be written on this document (Statement of Deficiencies - Form 2567 - right column) or documented in a separate letter on agency letterhead with each deficiency ' s prefix tag number separately stated and addressed. An acceptable Plan of Correction must include the following: 1. HOW the deficiency (state the deficiency prefix tag number - shown in left column of this document) will be or has been corrected. 2. WHAT monitors will be put in place to assure continuing compliance. 3. WHO is responsible for the Correction, and 4. WHEN (in far right column on this form) each deficiency will be corrected (include a calendar date). PLEASE SEND PLAN OF CORRECTION AND A SIGNED and INITIALED COPY OF THIS REPORT TO ADDRESS ON THE LEFT SIDE: SIGN HERE	

Patricia Terry MPA, RN
Department of Health
Office of Investigation and Inspection
P.O. Box. 47874
Olympia, WA 98504
Phone: 360-236-2921

ADSA — Residential Care Services or Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Director | (X6) DATE: 3/23/16

State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011452	A. BUILDING: _____ B. WING _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE HOME HEALTH	6410 NE HALSEY STREET, SUITE 200 PORTLAND, OR 97213

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z1130	246-335-080(1)(a) Home Health Plan of Care WAC 246-335-080 Home health plan of care. (1) Home health licensees must, except as provided in subsections (2) and (3) of this section: (a) Develop and implement a written home health plan of care for each patient with input from the patient or designated family member and authorizing practitioner; This Washington Administrative Code is not met as evidenced by: Based on interview, record review, and observation, the agency failed to implement the Plan of Care for 1 of 3 patients in the survey sample (Patient #2). Failure to implement the Plan of Care placed Patient #2 at risk of physical harm when interventions are not performed as ordered. Background: The State of Washington In-Home Services licensing regulations, Washington Administrative Codes (WAC) 246-335-080, defines the requirement HOME HEALTH licenses to develop and implement a written home health plan of care that includes the certain required elements: WAC 246-335-080 (1) - (c) Assure the home health plan of care includes: (iii) Types and frequency of services to be provided; Findings:	Z1130	How: Deficiency Z1130 was addressed with clinician involved by reviewing what is included in respiratory assessment. Staff education will be included in next staff meeting to review respiratory assessment. What: Follow-up visit will be made with involved clinician. This patient is currently out of town for a month and will not be back until April 1, 2016. Ongoing random chart audits will be done for any patient receiving Prolastin therapy to assess respiratory status until we are 100% compliant. Who: Clinical Infusion Nursing Manager. When: Visit will be done by April 30, 2016 Will begin chart audits April 1st and audit 30 charts with routine CQI on quarterly basis through 12/31/2016 to check for compliance.	

State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011452	A. BUILDING: _____ B. WING _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE HOME HEALTH	6410 NE HALSEY STREET, SUITE 200 PORTLAND, OR 97213

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z1130	Continued From page 2	Z1130		

1. The surveyor reviewed Patient #2's record on 02/12/2012. The surveyor visited the residence of Patient #2 to observe skilled nursing care being delivered on 02/11/2016 @ 11:30 AM.

2. The agency admitted Patient #2 on 11/07/2014 with a diagnosis of Alpha-1-antitrypsin deficiency (an inherited disease that can damage the lungs causing difficulty breathing, shortness of breath and a chronic cough).

3. Prior to the home visit on 02/11/, the surveyor reviewed Patient #2's Plan of Care (POC) on 02/10/2016. The surveyor noted that the POC included specific goals and interventions for the category of "Pulmonary" (refers to the lungs and all aspects of breathing).

The POC included an ordered intervention of "Assess respiratory status at every visit". The surveyor interviewed the Clinical Manager on 02/10/2016 @ 11:00 AM and asked him/her to describe what an assessment of respiratory status would include. The Clinical Manager stated, "It would include listening to breath sounds, asking if the patient feels short of breath, asking if the patient has had a productive cough, and noting the patient's respiratory rate (breaths per minute)".

4. During the home visit on 02/11/2016, the surveyor observed Employee C providing skilled nursing services. The surveyor noted that by the conclusion of the visit, Employee C had not listened to Patient #2's lungs in order to assess breath sounds. The surveyor asked Employee C why he/she had omitted this. Employee C

State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011452	A. BUILDING: _____ B. WING _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE HOME HEALTH	6410 NE HALSEY STREET, SUITE 200 PORTLAND, OR 97213

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z1130	Continued From page 3 replied, "The patient doesn't really like me to do that do I just ask about (his/her) breathing instead". The surveyor observed that Employee C did not ask Patient #2 if he/she could check their breath sounds. The agency's Clinical Manager confirmed this finding on 02/12/2016.	Z1130		
Z1200	246-335-080(1)(c)(vi) Home Health Plan of Care WAC 246-335-080 Home health plan of care. (1) Home health licensees must, except as provided in subsections (2) and (3) of this section: (c) Assure the home health plan of care includes: (vi) Special nutritional needs and food allergies; This Washington Administrative Code is not met as evidenced by: . Based on record review and interview, the agency failed to ensure the Plan of Care (POC) included documentation of patients' food allergies for patients for 3 of 3 patients in the survey sample (Patient ' s #1, #2, and #3). Failure to meet this requirement may result in physical harm to patients when allergic reactions to food are unknown to agency staff. Findings: 1. The surveyor reviewed the records for Patients #1, #2 and #3 on 02/11/2016.	Z1200	How: Deficiency Z1200 for all patients under allergy tab in electronic medical record, it will clearly state if patient does or does not have food allergies. (Pharmacy does do food allergy assessment as stated in policy SP205-3, and this is documented in Pharmacy care plan under pharmacy initial assessment. Problem reads, "Interactions/contraindications drug/diet/disease/lab." Pharmacist/RN education will be done by clinical nursing manager by March 31, 2016. What: Chart audits are done quarterly on patient allergies. We will continue to monitor for compliance and include documentation which states patient assessed for food allergies and document if patient does or does not have food allergies. Who: Clinical Infusion Manager When: Will begin chart audits April 1 and audit 30 charts with routine CQI on quarterly basis through 12/31/2016 to check for compliance.	

State of Washington

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	011452	A. BUILDING: _____ B. WING _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Z1200	Continued From page 4 2. The surveyor examined each Electronic Medical Record(s) - EMR - of Patients #1, #2 and #3. For each of these records, there was no documentation of the presence or absence of food allergies on the POC. 3. The surveyor interviewed the Clinical Manager on 02/11/2016 @ 1:00 PM regarding this finding. He/she stated that staff always document the presence or absence of a drug allergy, but do not routinely do so for food allergies. The agency ' s Clinical Manager confirmed this finding on 02/12/2016.	Z1200		
Z1210	246-335-080(1)(c)(vii) Home Health Plan of Care WAC 246-335-080 Home health plan of care. (1) Home health licensees must, except as provided in subsections (2) and (3) of this section: (c) Assure the home health plan of care includes: (vii) Orders for medications to be administered and monitored by the licensee including name, dose, route, and frequency; This Washington Administrative Code is not met as evidenced by: Based on record review and interview, the agency failed to appropriately document orders for medications to be administered to 1 of 3 patients (Patient #2). Failure to document a complete list of medications resulted in a medication list that was incomplete, potentially causing physical harm to	Z1210	How: Deficiency has been addressed and corrected. Order sent to MD for anaphylactic kit per pharmacy protocol for first dose and all consecutive infusion What: Epipen order has been ended on patient medication list. Specialty Pharmacy Services will send standing order for Anaphylactic kit protocol on any patients receiving infusion services. Chart audits will done until 100% complianc Who: Clinical Infusion Manager / Pharmacy When: Order sent to MD on 3/18/2016. Has been corrected. Signed order received from MD 3/21/2016. See attached documentation. Will begin chart audits April 1 and audit 30 charts with routine CQI on quarterly basis through 12/31/2016 to check for compliance.	

State of Washington

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE HOME HEALTH	6410 NE HALSEY STREET, SUITE 200 PORTLAND, OR 97213

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z1210	Continued From page 5 Patient #2. Findings: 1. The surveyor reviewed the records for Patients #2 on 02/11/2016. 2. The agency admitted Patient #2 on 11/07/2014 with a diagnosis of Alpha-1-antitrypsin deficiency (an inherited disease that can damage the lungs causing difficulty breathing, shortness of breath and a chronic cough). 3. The surveyor examined each Electronic Medical Record(s) - EMR - of Patients #2 and noted a discrepancy between the physician's order for an emergency medication and the patient's medication list. o The Plan of Care (POC) includes the following physician order: "Epipen 0.3 mg injection from autodevice as needed for allergic reaction". o The POC section titled "Medications" did not include this order. 4. The surveyor interviewed the agency's Clinical Manager regarding this finding on 02/11/2016 @ 1:30 PM. He/she stated, "It (the Epipen) should be on the medication list". The agency's Clinical Manager confirmed this finding on 02/12/2016.	Z1210		
Z1340	246-335-080(1)(d)(v) Home Health Plan of Care WAC 246-335-080 Home health plan of care. (1) Home health licensees must, except as provided in subsections (2) and (3) of this	Z1340	How: Deficiencies have been addressed and corrected. Order sent to MD for Anaphylactic kit per pharmacy protocol for first dose and all consecutive infusions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011452	A. BUILDING: _____ B. WING _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE HOME HEALTH	6410 NE HALSEY STREET, SUITE 200 PORTLAND, OR 97213

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z1340	Continued From page 6 section: (d) Develop and implement a system to: (v) Obtain approval from the authorizing practitioner for additions and modifications; This Washington Administrative Code is not met as evidenced by: Based on record review, interview, and observation, the agency failed to ensure that agency staff obtained approval from the authorizing practitioners to change the manner in which a medication was to be given for 1 of 3 patients, thereby modifying the Plan of Care (Patient #2). Failure of the agency to obtain approval from an authorizing practitioner of modifications and/or additions to the POC, places patients at risk of physical harm when the authorizing practitioners are not fully informed of factors that could affect their patient's well-being. Findings: 1. The surveyor reviewed the records for Patients #2 on 02/11/2016. Additionally, the surveyor made a home visit to the residence of Patient #2 on 02/11/2016 to observe skilled nursing services being provided by Employee C. 2. The agency admitted Patient #2 on 11/07/2014 with a diagnosis of Alpha-1-antitrypsin deficiency (an inherited disease that can damage the lungs causing difficulty breathing, shortness of breath and a chronic cough). 3. During the review of Patient #2's Electronic Medical Record - EMR on 02/10/2016, the surveyor noted the following physician order:	Z1340	What: Specialty Pharmacy Services will send standing order for Anaphylactic kit protocol on any patients receiving infusion services. Chart audits will be done until 100% compliance. Who: Clinical Infusion Manager / Pharmacy When: Order sent to MD on 3/18/2016. Has been corrected. Signed order received from MD 3/21/2016. See attached documentation. Will begin chart audits April 1 and audit 30 charts with routine CQI on quarterly basis through 12/31/2016 to check for compliance.	

State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011452	A. BUILDING: _____ B. WING _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE HOME HEALTH	6410 NE HALSEY STREET, SUITE 200 PORTLAND, OR 97213

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Z1340	Continued From page 7 "Epipen 0.3 mg injection from autodevice as needed for allergic reaction". During the home visit on 02/12/2016 (starting @ 11:30 AM), the surveyor attempted to confirm that an Epipen device was present in the home. Employee C stated, "We don't supply the Epipen, they cost too much and they expire too quickly". Employee C explained that instead of using an Epipen as ordered, each file nurse carries a multi-dose vial of Epinephrine to use in the event of an emergency. The surveyor confirmed that the agency had not obtained an order from the physician to make this change to the POC. The agency's Clinical Manager confirmed this finding on 02/12/2016.	Z1340		