SWEDISH

September 7, 2018

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

Re: Application for a Pediatric Intensive Care Unit (PICU) – Issaquah, WA

Dear Ms. Sigman:

Enclosed please find two copies of the certificate of need application to convert six existing acute care beds into a six bed Pediatric Intensive Care Unit (PICU) at Swedish Issaquah. As required, the review and processing fee of $40,470 is also enclosed.

We look forward to working with the Department in its review of the application. If you have any questions, please contact me at (206) 628-2552.

Sincerely,

Heidi Aylsworth
Chief Strategy Officer
Swedish Health Services
747 Broadway
Seattle, WA 98122

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

APPLICATION FOR CERTIFICATE OF NEED
Hospital Projects

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

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

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

APPLICANT(S)

(PLEASE PRINT OR TYPE)

OWNER:

Name and Title of Responsible Officer:
Heidi Aylsworth, Chief Strategy Officer

Legal Name of Owner:
Swedish Health Services

Address of Owner:
747 Broadway
Seattle, WA 98122

Signature of Responsible Officer:

Date: 9/7/18 Telephone: (206) 628-2552

(PLEASE PRINT OR TYPE)

OPERATOR:

Name and Title of Responsible Officer:
Chris Beaudoin, Chief Operations Officer

Legal Name of Operator:
Swedish Issaquah

Address of Operator:
751 NE Blakely Drive
Issaquah, WA 98209

Signature of Responsible Officer:

Date: 9/7/18 Telephone: (425) 313-4458

TYPE OF OWNERSHIP:

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

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

OPERATION OF FACILITY:

- ☒ Owner Operated
- ☐ Management Contract
- ☐ Lease

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

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

Intended Project Start Date:

Upon certificate of need approval. Estimated Date: Sept., 2019

ESTIMATED CAPITAL EXPENDITURE:

$290,000

Project Description: Convert six existing acute care beds into a six bed PICU within existing hospital.

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

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

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

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

2. COMPLETE THE FOLLOWING PRIOR TO SUBMISSION FOR REVIEW:

TOTAL AMOUNT OF FEE ACCOMPANYING THIS APPLICATION:

REVIEW FEE: $40,470

APPLICANT NAME: Swedish Health Services

DATE OF SUBMISSION: September 7, 2018 CHECK NUMBER:[1] 688358

[1] Please see Exhibit 1 for a copy of the check to DOH

APPLICATION INFORMATION INSTRUCTIONS

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

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

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

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

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

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

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

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

Swedish Health Services

Certificate of Need Application

Establish Pediatric Intensive Care Services at Swedish Issaquah

September 7, 2018

Table of Contents

Exhibits

I. APPLICANT DESCRIPTION

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

The applicant's legal name is Swedish Health Services.

B. Address of each applicant.

Swedish Health Services
747 Broadway
Seattle, WA 98122-4307

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

Swedish Health Services is a Washington not-for-profit corporation; therefore, the question is not applicable.

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

Please see the table below for list of Swedish owned and operated facilities.

Name	Address	Medicare Provider Number	Medicaid Provider Number	Owned or Managed
Swedish/First Hill	747 Broadway Seattle, WA 98122-4307	50-0027	3309200	Owned
Swedish/Ballard	5300 Tallman Ave. N.W. Seattle, WA 98107-3985	50-0027	3309200	Owned
Swedish/Cherry Hill	500 17th Avenue Seattle, WA 98124	50-0025	3309507	Owned
Swedish/Edmonds	21601 76th Ave W Edmonds, WA 98026	50-0026	3341807	Managed

Swedish/Issaquah	751 NE Blakely Drive Issaquah, WA 98029	50-0152	2015502	Owned
Swedish/Mill Creek	13020 Meridian Ave South Everett WA 98208	50-0027	3309200	Owned
Swedish/Redmond	18100 NE Union Hill Road Redmond WA 98052	50-0027	3309200	Owned

E. Facility licensure/accreditation status.

Swedish Issaquah is licensed by the Washington State Department of Health and accredited by Det Norske Veritas Healthcare, Inc. (DNV).

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

Yes, Swedish Health Services is reimbursed under Titles V, XVIII, and XIX of the Social Security Act.

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

There have been no such convictions or sanctions as described in WAC 248-19-390(5)(a) (now codified at WAC 246-310-230(5)(a)) for Swedish Issaquah or Swedish Health Services.

II. FACILITY DESCRIPTION

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

Swedish Medical Center/Issaquah
751 NE Blakely Drive
Issaquah, WA 98029

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

Same as applicant.

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

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

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

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

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

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

The operating entity is the same as the applicant.

E. Geographic identity of primary service area.

For purposes of this certificate-of-need application, the Planning Area is defined as "King East" in WAC 246-310-705. The zip codes included in this King East Planning Area are listed in Exhibit 3.

F. Peer Group.

This question is not applicable as there are no other pediatric intensive care services provided in the East King planning area. The closest providers of PICU services are located in the Central King planning area (Swedish First Hill and Harborview) and in the North King planning area (Seattle Children's).

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

Swedish Medical Group (SMG) currently employs six pediatric critical care physicians:

Isabel Belem, MD	Andre Fallot, MD
Omar Chikovani, MD	Jordan Greenberg, MD
David Colvin, MD	Michael Shannon, MD

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

There are currently no pediatric intensive care services provided in the primary service area of East King. Therefore this question is not applicable.

I. For existing hospitals, provide:

Inpatient days/year for the last five years

There are currently no pediatric intensive care services provided at the Swedish Issaquah campus. However, Swedish currently offers pediatric intensive care services on its First Hill Campus. The total inpatient days in the current six bed PICU at the Swedish First Hill Campus are:

	2013	**2014**	**2015**	**2016**	**2017**
FH PICU Pt Days	1,069	928	1,200	1,192	959

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

This question is not applicable. The project includes remodeling but will fit within Swedish Issaquah's existing structures.

III. PROJECT DESCRIPTION

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

Swedish Health Services requests approval to establish pediatric intensive care services at Swedish Issaquah. If approved, Swedish would dedicate six beds for a Pediatric Intensive Care Unit (PICU) within its existing hospital license. Currently, these six beds are acute care beds which are being used for general medical/surgical patients at Swedish Issaquah.

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

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

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

The proposed project does not involve purchasing an existing service. There are currently no PICU beds within the East King planning area.

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

Swedish Issaquah is currently licensed for 144 beds. Construction is currently underway to add the 31 additional beds approved under CN #1379A2 to achieve our planned licensed capacity of 175 beds. This work will be complete by October 2018. The PICU project proposed in this CN application will not increase the 175 beds at Swedish Issaquah nor change the bed type. It will simply add a new tertiary service within the 175 approved licensed beds.

Bed Type	Current	Fall 2018	After PICU CN
Med/Surg/ICU	129	160	160
Level II Intermediate Care Nursery	15	15	15
Total Licensed Bed Capacity	**144**	**175**	**175**

E. Total estimated capital expenditures.

The capital expenditure for this project is $290,000.

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

An estimate of the facility-wide operational expenses for Swedish Issaquah for the first two years of operation (with and without the project) are as follows:

Swedish Issaquah Facility-Wide Operating Expenses Without Project

Year	Total Operating Expense
2019	$166,628,211
2020	$167,757,706
2021	$168,895,107
2022	$170,040,470

Source: Swedish financial statements

Swedish Issaquah Facility-Wide Operating Expenses With Project

Year	Total Operating Expense
2019	$168,107,257
2020	$172,194,844
2021	$173,363,305
2022	$174,539,946

Please see Exhibit 4 for the proforma financial statements without the project and Exhibit 5 for the proforma financial statements with the project.

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

The proposed pediatric intensive care unit (PICU) at Swedish Issaquah would serve the same types of patients seen today in the PICU at Swedish First Hill. It would serve both medical and surgical pediatric patients.

Common conditions of patients on the unit would include, but not be limited to:

- Severe respiratory illnesses including asthma, pneumonia and RSV
- Viral and bacterial meningitis
- Seizures
- Post-surgery patients requiring close monitoring

There are select types of pediatric patients that will not be within the scope of services provided within the PICU at Swedish Issaquah. These include pediatric transplant patients, pediatric patients requiring advanced cancer treatment or pediatric trauma patients. These pediatric patients will need to continue to receive care outside of the East King planning area.

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

We project the inpatient days in the PICU at Swedish Issaquah to be as follows:

Swedish Issaquah PICU Patient Day Forecast

	2019	2020	2021	2022
Total Patient Days	333	1,000	1,007	1,014

We anticipate that 2019 will be a partial year of operation for the PICU in Issaquah and therefore our first full year of operation will be in 2020.

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

This question is not applicable. The PICU will be located on an existing inpatient care unit on the Swedish Issaquah campus, so patient care will have minimal to no disruption from current state.

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

The 2017 payor mix for Swedish Issaquah by total charges was as follows:

Source	Percent
Medicare	35.7%
Medicaid	10.7%
Commercial	49.9%
Self-pay	3.6%
Total	**100%**

K. Sources of financing.

Swedish Health Services will provide cash reserves to fund the proposed project. There will be no debt financing.

L. Equipment proposed:

1. Description of new and replacement equipment proposed.

Since the proposed six bed PICU will be a conversion of six current adult medical/surgical beds, a majority of the equipment will already be in place as it can be utilized with either adult or pediatric patients (monitors, IV poles, etc.) The minimal amount of pediatric specific equipment (e.g. beds) needed for the PICU will be relocated from extra existing equipment at other Swedish locations. A small budget of $40,000 has been built into the project budget for the minor equipment required to set up the PICU.

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

Any adult equipment currently utilized in the six rooms that will become the PICU will be relocated to other locations within Swedish Issaquah or Swedish Health Services. We do not anticipate that any equipment will need to be disposed of as a result of this project.

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

Please refer to Exhibit 6 for drawings of the current patient care floor where the PICU will be located.

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

Please refer to Exhibit 6 for drawings of patient care floor with the proposed PICU. The primary changes that will take place during the remodel of the current unit to the proposed unit are:

- Conversion of 6 med/surg rooms into PICU rooms (shown on the exhibit in green)
- Conversion of a current PT/OT gym to a play area and office space for child life specialists (shown on the exhibit in green)
- Paint
- Signage
- Minor low voltage cabling to accommodate equipment

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

1. Indicate the number of acres in the site:

This question and subsequent questions 2-8 are not applicable. The proposed project will be within the current Swedish Issaquah campus.

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

This question is not applicable.

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

This question is not applicable.

4. **Address of the site:**

This question is not applicable.

Address of alternative site:

This question is not applicable.

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

This question is not applicable.

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

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

This question is not applicable.

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

   This question is not applicable.

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

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

      This question is not applicable.

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

      This question is not applicable.

   c. **A lease for at least one year with options to renew for not less than a total of five years in the case of freestanding kidney dialysis units, ambulatory surgical facilities, hospices, or home health agencies; or**

      This question is not applicable.

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

      This question is not applicable.

P. Space Requirements

1. Existing gross square feet:

This question is not applicable. No additional space will be added to Swedish Issaquah as a result of this project. The project will only require a minor remodel of current space.

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

This question is not applicable. No additional space will be added to Swedish Issaquah as a result of this project. The project will only require a minor remodel of current space.

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

This question is not applicable. No additional space will be added to Swedish Issaquah as a result of this project. The project will only require a minor remodel of current space.

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

The proposed project will not include any shelled-in areas.

Q. Proposed Timetables for Project Implementation.
The Certificate of Need Program will use the following timetable in monitoring the applicant's conformance with the issued Certificate of Need. Failure to meet the specified timetable may be grounds for revocation of a Certificate of Need. (WAC 246-310-500)

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

a. Date for obtaining construction financing.

This question is not applicable.

b. Date for obtaining permanent financing.

This question is not applicable.

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

This question is not applicable. Exhibit 10 contains a letter from the Swedish CFO confirming the funds to complete this project are currently available.

2. Design

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

April 2019

The Design and Construction schedule may commence earlier, depending upon the date of Certificate of Need approval.

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

May 2019

3. Construction

a. Date for construction contract award.

May 2019

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

June 2019

c. Date for 50 percent completion of construction.

July 2019

d. Date for 75 percent completion of construction.

July 2019

e. Date for completion of construction.

July 2019

f. Date for obtaining licensure approval.

July 2019

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

September 2019

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

The proposed PICU would only require a minor remodel to a current patient unit within Swedish Issaquah. Swedish Health Services has significant experience with this type of project.

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

This project is included in both the long range strategic and financial plans for Swedish Health Services.

IV. PROJECT RATIONALE

A. NEED

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

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

There are currently no pediatric intensive care services provided in the East King planning area. Currently residents of East King need to travel to Seattle to Swedish First Hill, Harborview or Seattle Children's to access PICU services. These hospitals are located in the Central and North King planning areas.

A traditional numerical bed need calculation has not been included as part of this application since there is no request for additional beds within the East King planning area as part of this proposal. We are simply requesting to add a tertiary service to the Swedish Issaquah Campus.

The table below illustrates a high level demand analysis for PICU beds within the East King planning area. It illustrates that the population of the East King planning area could support six PICU beds. For the purpose of this analysis, pediatrics was defined as age 0-17.

Admit Year	2013	2014	2015	2016	2017	Definition/Rationale
Total Peds Admits	1,683	1,674	1,722	1,647	1,383	2017 East King Pediatric Admits, Excl. Neonatology, Obstetrics, and Behavioral Health (Data source: CHARS, 2017)
Estimated PICU admits	337	335	344	329	277	2017 Estimted East King PICU admits, assuming 20% of total peds admits (Swedish historic experience as percentage of total Peds admits)
Estimated PICU days	1,885	1,875	1,929	1,845	1,549	2017 Estimated East King PICU patient days, assuming 5.6 day ALOS (2017 Swedish ALOS stay for intensive level pediatric inpatient)
Bed need, 100% occupancy	5.2	5.1	5.3	5.1	4.2	East King estimated bed need, assuming 365 day year with 100% occupancy efficiency
Bed need, 70% occupancy	**7.4**	**7.3**	**7.5**	**7.2**	**6.1**	East King estimated bed need, assuming 365 day year with 70% efficiency

As outlined on page 9 above, the proposed PICU at Swedish Issaquah is projected to have 1,000 patient days in the year 2020. This would translate to an average need for 4 PICU beds at Swedish Issaquah at an occupancy rate of 70% (1,000/365/0.7).

We are proposing to establish a six bed PICU to accommodate seasonal fluctuations in census and future population growth.

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

If not approved all of the residents of the East King planning area would need to continue to leave the planning area to obtain pediatric intensive care services. If this project is approved, a significant number of these patients would be able to receive PICU level care closer to home.

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

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

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

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

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

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

According to the 2016 Washington State Charity Care Report (dated 2018) Swedish has provided charity care at the following rates as a percentage of adjusted patient service revenue for its three King County hospitals:

Swedish Cherry Hill	2.45%
Swedish First Hill	1.71%
Swedish Issaquah	1.49%

Swedish is committed to providing healthcare services to all persons, without regard to income, race, ethnicity, sex, handicap, or any other factor. Swedish also is committed to caring for each person needing care, regardless of his or her ability to pay.

In addition to the charity care discussed above, Swedish also devotes substantial resources to health-related research, community health activities, and medical education. As a charitable, nonprofit 501(c)(3) organization, Swedish invests its resources in programs and services that improve the health of the community and region, from building partnerships with community clinics that serve the underprivileged to providing free and low-cost health-education classes to the public.

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

This proposed project would bring pediatric intensive care services to the residents of East King County which are currently not available in their planning area. Currently, PICU services are only available in Seattle in the Central and North King County planning areas.

c. Applicants should include the following:

Copy of admissions policy

Please refer to Exhibit 7 for a copy of the Swedish admission and patient rights and responsibilities policy.

Copy of community service policy

Please refer to Exhibit 8 for a copy of the Swedish Charity Care Policy.

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

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

Other information as appropriate.

This question is not applicable.

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

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

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

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

   There are no pediatric intensive care services provided within the East King planning area. The proposed PICU at Swedish Issaquah would be able to serve a significant portion of the patients aged 0-17 in East King County who have a wide variety of pediatric intensive care needs ranging from asthma to post-surgical monitoring.

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

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

      Currently, there are no pediatric intensive care services provided within the East King planning area. The only PICU beds in King County are located at Swedish First Hill, Harborview and Seattle Children’s which are located in Seattle in the Central and North King planning areas.

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

Currently, there are no pediatric intensive care services provided within the East King planning area.

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

Currently, there are no pediatric intensive care (PICU) beds within the East King planning area.

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

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

We project the inpatient days in the PICU at Swedish Issaquah to be as follows:

Swedish Issaquah PICU Patient Day Forecast

	2019	2020	2021	2022
Total Patient Days	333	1,000	1,007	1,014

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

The utilization forecast was derived by reviewing the current PICU utilization over the last 5 years at the Swedish First Hill Campus (outlined below in question 5d) as well as the potential market demand for PICU services in the East King planning area (outlined below in question 5e).

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

The assumptions related to use rate and intensity of service for the proposed PICU are outlined below in question 5e. The assumption is that the intensity of service provided in the PICU at Swedish Issaquah

would be equivalent to the intensity of services provided in the PICU at Swedish Issaquah today.

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

There are currently no pediatric intensive care unit (PICU) beds on the Swedish Issaquah campus. However, Swedish currently offers PICU services on its First Hill campus. The total inpatient days in the current Swedish PICU at the Swedish First Hill Campus are:

	2013	2014	2015	2016	2017
PICU Patient Days (Swedish FH)	1,069	928	1,200	1,192	959

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

Since PICU level beds do not currently exist in the East King planning area, the table below is an estimate of the potential patients in the East King planning area who could begin to use the PICU beds at Issaquah if this project is approved.

Admit Year	2013	2014	2015	2016	2017	Definition/Rationale
Total Peds Admits	1,683	1,674	1,722	1,647	1,383	2017 East King Pediatric Admits, Excl. Neonatology, Obstetrics, and Behavioral Health (Data source: CHARS, 2017)
Estimated PICU admits	337	335	344	329	277	2017 Estimted East King PICU admits, assuming 20% of total peds admits (Swedish historic experience as percentage of total Peds admits)
Estimated PICU days	1,885	1,875	1,929	1,845	1,549	2017 Estimated East King PICU patient days, assuming 5.6 day ALOS (2017 Swedish ALOS stay for intensive level pediatric inpatient)
Bed need, 100% occupancy	5.2	5.1	5.3	5.1	4.2	East King estimated bed need, assuming 365 day year with 100% occupancy efficiency
Bed need, 70% occupancy	**7.4**	**7.3**	**7.5**	**7.2**	**6.1**	East King estimated bed need, assuming 365 day year with 70% efficiency

We have projected 1,000 patient days in 2020 for the proposed PICU at Swedish Issaquah.

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

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

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

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

      Swedish Health Services partners with educational institutions throughout the Puget Sound to serve as a training site for students from various disciplines who wish to prepare themselves for a future in a health care related field.

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

      As a tertiary care referral center, Swedish Health Services maintains an active research department to conduct research relevant to improving patient care in a wide variety of specialties. We combine the talents and skills of world-class physicians and highly-trained research staff to make the Swedish Clinical Research division one of the best in the Pacific Northwest.

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

      Not applicable.

B. Financial Feasibility

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

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

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

The anticipated cost of this project is as follows:

Question	Total Project
a. Land Purchase	NA
b. Land Improvements	NA
c. Building Purchase	NA
d. Residual Value of Assets Being Replaced	NA
e. Construction Costs	$250,000
f. Moveable Equipment	$40,000
g. Fixed Equipment (which are not included in construction contract)	NA
h. Architect and Engineering Fees	Included in construction cost
i. Consulting Fees	Included in construction cost
j. Site Preparation	NA
k. Supervision and Inspection of Site	Included in construction cost
l. Costs associated with securing the Source(s) of financing listed under (2) below	NA
m. Cost of Financing to include interim interest during construction	NA
n. Washington State Sales Tax	Included in construction and equipment cost
o. Other itemized • Permits and Regulatory Review	Included in construction cost
p. Total Estimated Capital Cost (actual / replacement cost)	**$290,000**

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

Please see Exhibit 9 for a copy of the signed nonbinding construction estimate.

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

Cost Center/ Service	Estimated Gross Square Feet	Const. Cost/GSF (use e, f, g, i, j and k above)	Total Cost/Bed (use p above)	Total Cost/GSF (Use p above)
PICU	3,102	$122	$48,333	$122
Cost Center/ Service	Estimated Net Square Feet	Const. Cost/NSF (use e, f, g, i, j and k above)	Total Cost/Bed (use p above)	Total Cost/NSF (Use p above)
PICU	2,386	$93	$48,333	$93

Note: A grossing factor of 1.3 was used to convert actual net square feet to gross square feet.

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

The project capital cost for the project is $290,000. At an estimated 1,000 patient days the average capital cost increase per patient day would be $290.

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

The anticipated sources of financing for this project are as follows:

Question	Specify Type	Amount
a. Public Campaign		
b. Bond Issue		
c. Commercial Loans		
d. Government Loans		
e. Grants		

Question	Specify Type	Amount
f. Bequests and Donations		
g. Private Foundations		
h. Accumulated Reserves		$290,000
i. Internal Loans		
j. Capital Allowance		
k. Other – specify		
l. Total (should equal total project cost)		**$290,000**

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

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

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

There will be no construction loans.

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

This question is not applicable.

9. Estimated Start - up and Initial Operating Expenses.

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

Not applicable. Swedish currently has staff trained to provide pediatric intensive care services.

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

This question is not applicable. Swedish Issaquah is currently operational.

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

This question is not applicable.

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

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

10. Evidence of Availability of Financing for the Project. Please submit the following:

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

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

This question is not applicable. Please see Exhibit 10 for a letter of financial commitment.

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

Please refer to Exhibit 10 for a letter of financial commitment.

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

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

d. Amortization schedule(s) for each financing arrangement including long term and any short term start-up or initial operating deficit loans, setting forth the:
i. Principal
ii. Term (number of payment periods) (long term loans

may be annualized)

iii. Interest

iv. Outstanding balance at end of each payment period

This question is not applicable.

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

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

Given the minor cost of this remodel in relationship to the revenue generated by Swedish Health Services it is most appropriate to fund this project internally through the use of accumulated cash reserves.

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

Please refer to Exhibit 4 (Proforma and Cost Center Statements of Revenue and Expense without Project) and Exhibit 5 (Proforma and Cost Center Statements of Revenue and Expense with Project).

The key assumptions for the financial models include the following:

Volume – the patient day estimates utilized in the model and outlined above in question 5a were based on the estimated need for pediatric intensive care services in East King as described above under question 5e. 2019 was assumed to be a partial year of operations with 2020 being the first full year of operations.

Length of Stay – was based on actual data from the Swedish First Hill PICU.

Revenue – was based on our actual charges from the Swedish First Hill PICU. Net revenue calculated using the Swedish Issaquah payer mix. Charity care is assumed to be constant to the current rate at Swedish Issaquah. Inflation of gross and net revenues was excluded from the model.

Expenses – were based on actual data from the Swedish First Hill PICU.

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

Swedish does not maintain a separate balance sheet or cash flow statement. These are kept at the corporate level. Please see Exhibit 11 for PH&S audited financial statements for 2015 and Providence St Joseph Health audited financial statements for 2016-2017.

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

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

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

We anticipate the percentage of revenue from each payer source to be as follows:

Source	Percent
Medicare	35.7%
Medicaid	10.7%
Commercial	49.9%
Self-pay	3.6%
Total	**100%**

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

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

17. Provide the complete audited year-end financial reports for the last three full fiscal years. These should include balance sheets, expense and revenue statements, statements of changes in financial position, and the accompanying notes.

Please see Exhibit 11 for PH&S audited financial statements for 2015 and Providence St Joseph Health audited financial statements for 2016-2017. Swedish does not maintain a separate balance sheet or cash flow statement. These are kept at the corporate level.

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

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

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

We anticipate that the addition of the pediatric intensive care services to Swedish Issaquah can be accomplished without any incremental FTE additions or reductions to Swedish as a system. A reallocation of staffing resources would take place within Swedish to accommodate appropriate staffing for this new service.

C. Structure and Process (Quality) of Care.

1. Document the following:

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

We do not anticipate any staffing challenges. Swedish has an excellent reputation and history of being able to retain and recruit appropriate personnel.

b. In the context of the State Health Plan Health Facility / Service General Performance Standard # 2h, document the present and future availability of personnel with qualifications appropriate to

the level of intensity of care they are and/or will be providing and with training specific to the technologies they are using.

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

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

Swedish Issaquah is an existing acute care hospital providing high quality patient services, which includes appropriate ancillary and support services. Swedish Issaquah has expanded ancillary services that ensure efficiency and access to state-of-the-art diagnostic and therapeutic services to serve all patients in the best possible manner. The existing ancillary and support services will be able to support the proposed PICU patient population.

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

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

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

Swedish has developed long-term collaborative relationships with other providers to expand program offerings and ensure access and continuity of appropriate care for residents of King County and beyond. We will continue to evolve our relationship with hospitals, nursing homes, and other providers as we finalize our operational plans over the next year. Our processes and relationships are reviewed annually to maintain strong inclusive relationships and processes for the care continuum.

5. In the context of the State Health Plan Health Facility / Service General Performance Standard # 2g, document that your facility ensures and/or will ensure effective continuity of care through discharge planning initiated early in the course of treatment.

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

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

Please see Exhibit 7 for a copy of the Swedish admissions policy.

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

Swedish Health Services has no history of criminal convictions related to ownership / operation of a health care facility, licensure revocations or other sanctions described in WAC 246-310-230(5)(a). (Note: the above WAC has been re-codified as WAC 246-310-230.) Patient care at Swedish Issaquah is and will continue to be provided in conformance with all applicable federal and state requirements.

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

As stated earlier, Swedish Health Services has a history of providing high quality health care services in a safe and appropriate manner. Swedish Issaquah is licensed by the State of Washington Department of Health, is Medicare certified, and is accredited by DNV.

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

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

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

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

D. Cost Containment

Document the following:

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

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

Given there are currently no pediatric intensive care services provided within the East King planning area, the only consideration was whether or not to bring this service to the residents of the planning area. In evaluating the need for these services by East King residents it was clear that providing this service at Swedish Issaquah was the best choice for Swedish and the residents of the East King planning area.

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

Swedish Health Services continually looks for ways to improve patient care, operational efficiency and patient throughput. We have implemented several initiatives during the last several years in order to create additional capacity and ensure patients are served in the right care setting at the right time.

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

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

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

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

Exhibit 1
Check to DOH

WARNING: FRONT OF ORIGINAL DOCUMENT HAS A COLORED BACKGROUND ON WHITE PAPER AND AN ARTIFICIAL WATERMARK ON THE REVERSE SIDE

SWEDISH

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

U.S. BANK
HAVRE, MT 59501
24 HOUR BANKING 1-800673-3555

19-10/1250

CHECK NUMBER	DATE	AMOUNT
688358	09/06/18	**$40,470.00

Swedish

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

TO THE ORDER OF
DEPARTMENT OF HEALTH
CERTIFICATE OF NEED PROGRAM
PO BOX 47852
OLYMPIA WA 98504-7852

⑈00688358⑈ ⑆125000105⑆ 153595372050⑈

Vendor Number: 13160 Vendor Name: DEPARTMENT OF HEALTH Check Number: 688358 Check Date: 09/06/18

Invoice	Inv. Date	PO Number	Comments	Gross	Discounts	Net Amount
CHK090518	09/05/18		ENV EO -APPL FOR PICU-ISSQ WA	40,470.00	0.00	40,470.00
				Total Check Amount:		$40,470.00

Exhibit 2
Letter of Intent

SWEDISH

August 6, 2018

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

Re: Letter of Intent – Pediatric Intensive Care Unit – Issaquah WA

Dear Ms. Sigman:

In accordance with WAC 246-310-080, Swedish Health Services submits this letter of intent to apply for a certificate of need to convert six (6) existing acute care beds into a six (6) bed Pediatric Intensive Care Unit (PICU) at Swedish Issaquah.

1. Description of proposed services:

The Parties propose to convert six (6) existing acute care beds into a six (6) bed Pediatric Intensive Care Unit (PICU) on the Swedish Issaquah campus.

2. Estimated cost of proposed project:

The estimated cost of the proposed project is $290,000.

3. Identification of the service area:

For purposes of certificate of need review, the service area is considered to be the East King Secondary Health Services Planning area.

Thank you for your attention to this matter. If you have any questions, please do not hesitate to contact me.

Sincerely,

Heidi Aylsworth
Chief Strategy Officer,
Swedish Health Services
(206) 628-2552

Exhibit 3
East King Planning Area Map and Definition by Zip Codes

Hospital Planning Area 14 - East King P.A

East King Planning Area		
County	**Zip Code**	**City**
King	98004	Bellevue
King	98005	Bellevue
King	98006	Bellevue
King	98007	Bellevue
King	98008	Bellevue
King	98009	Bellevue
King	98011	Bothell
King	98014	Carnation
King	98015	Bellevue
King	98019	Duvall
King	98024	Fall City
King	98027	Issaquah
King	98028	Kenmore
King	98029	Issaquah
King	98033	Kirkland
King	98034	Kirkland

East King Planning Area (cont.)		
County	**Zip Code**	**City**
King	98039	Medina
King	98040	Mercer Island
King	98041	Bothell
King	98045	North Bend
King	98050	Preston
King	98052	Redmond
King	98053	Redmond
King	98065	Snoqualmie
King	98072	Woodinville
King	98073	Redmond
King	98074	Sammamish
King	98075	Sammamish
King	98077	Woodinville
King	98083	Kirkland
King	98224	Baring
King	98288	Skykomish

East King Planning Area Map

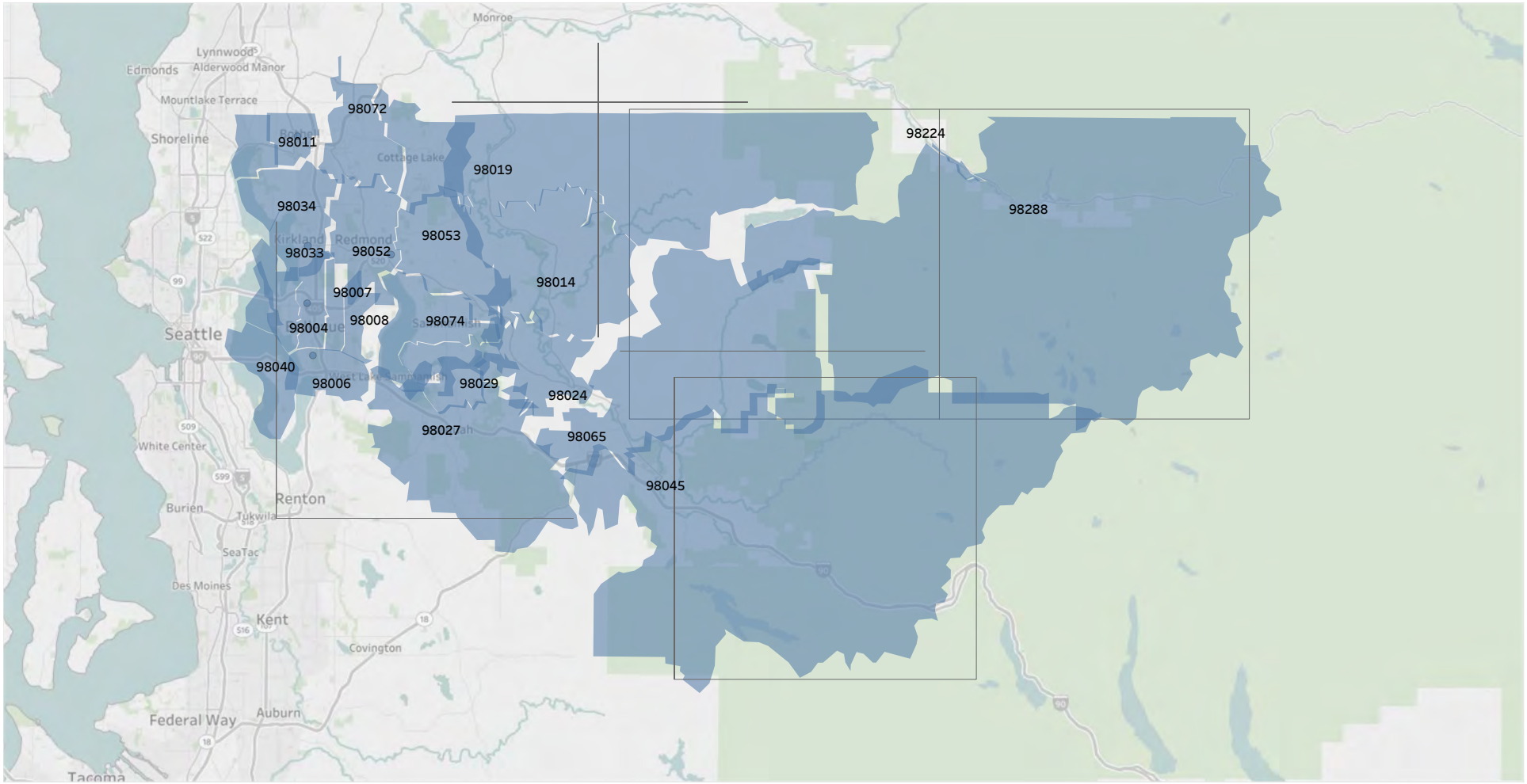


Exhibit 4
Proforma for Swedish Issaquah without Project

Swedish Issaquah
Statement of Revenues and Expenses Without the Project, 2018-2022

Income Statement

	Projected	Forecast			
	2018	2019	2020	2021	2022
Charges					
Inpatient Charges	$290,349,735	$295,917,681	$297,989,105	$300,075,029	$302,175,554
Outpatient Charges	$359,014,315	$366,194,601	$368,757,964	$371,339,269	$373,938,644
Total Charges	*$649,364,050*	*$662,112,282*	*$666,747,068*	*$671,414,298*	*$676,114,198*
Deductions from Revenue					
Deductions	$437,620,842	$446,212,159	$449,335,644	$452,480,993	$455,648,360
Charity Care	$7,155,037	$7,295,504	$7,346,573	$7,397,999	$7,449,785
Total Deductions	*$444,775,879*	*$453,507,663*	*$456,682,216*	*$459,878,992*	*$463,098,145*
Bad Debt	$6,672,889	$6,806,347	$6,853,991	$6,901,969	$6,950,283
Net Patient Service Revenue	*$197,915,282*	*$201,798,273*	*$203,210,861*	*$204,633,337*	*$206,065,770*
Other Operating Revenue	*$8,189,142*	*$8,186,154*	*$8,186,154*	*$8,186,154*	*$8,186,154*
Total Operating Revenue	**$206,104,424**	**$209,984,427**	**$211,397,015**	**$212,819,491**	**$214,251,924**
Operating Expenses					
Salaries	$59,011,500	$61,398,010	$61,811,041	$62,226,963	$62,645,797
Benefits	$9,428,163	$9,836,703	$9,902,876	$9,969,511	$10,036,614
Professional Fees	$4,851,402	$4,810,190	$4,842,549	$4,875,134	$4,907,947
Supplies	$30,049,161	$31,737,794	$31,951,298	$32,166,296	$32,382,799
Purchased Services	$16,266,250	$16,776,742	$16,889,601	$17,003,250	$17,117,694
Depreciation & Amortization	$16,078,189	$16,075,923	$16,188,454	$16,301,774	$16,415,886
Interest	$15,324,402	$15,324,404	$15,431,675	$15,539,697	$15,648,474
B&O Taxes and Safety Net	$6,561,027	$6,379,943	$6,422,862	$6,466,081	$6,509,602
Other	$4,155,167	$4,288,502	$4,317,351	$4,346,402	$4,375,657
Total Operating Expenses	*$161,725,261*	*$166,628,211*	*$167,757,706*	*$168,895,107*	*$170,040,470*
Operating Margin before Allocations	*$44,379,163*	*$43,356,216*	*$43,639,309*	*$43,924,384*	*$44,211,454*
Allocations					
Corp Services Allocation	$73,190,812	$74,654,628	$76,147,721	$77,670,675	$79,224,089
Total Allocations	*$73,190,812*	*$74,654,628*	*$76,147,721*	*$77,670,675*	*$79,224,089*
Operating Income after Allocations	*($28,811,649)*	*($31,298,412)*	*($32,508,412)*	*($33,746,292)*	*($35,012,635)*
Non-operating Income					
Investment Income	$0	$0	$0	$0	$0
Foundation Unrealized Gain / (Loss)	$0	$0	$0	$0	$0
Foundation Contributions - Unrestrict	$0	$0	$0	$0	$0
Gain / (Loss) on Sale of Assets	$0	$0	$0	$0	$0
Other Non-operating Income	$0	$0	$0	$0	$0
Total Non-operating Income	*$0*	*$0*	*$0*	*$0*	*$0*
Net Income / (Loss)	**($28,811,649)**	**($31,298,412)**	**($32,508,412)**	**($33,746,292)**	**($35,012,635)**

Source: Issaquah, 2018

Exhibit 5
Proforma for Swedish Issaquah with Project

Swedish Issaquah
Statement of Revenues and Expenses With the Project, 2018-2022

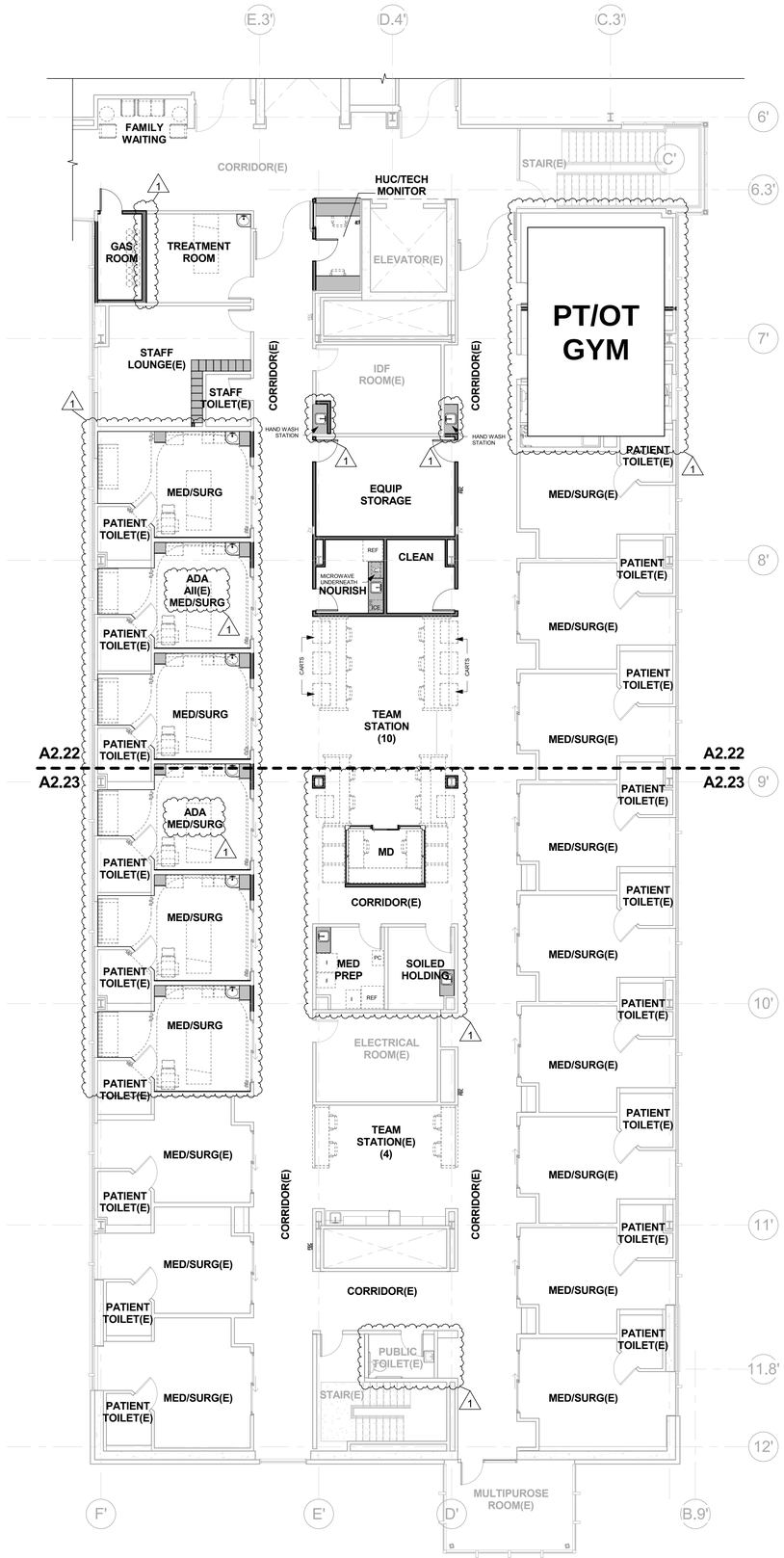
Income Statement

	Projected	Forecast			
	2018*	2019	2020	2021	2022
Charges					
Inpatient Charges	$290,349,735	$300,498,267	$311,730,864	$313,912,980	$316,110,371
Outpatient Charges	$359,014,315	$366,512,426	$369,711,438	$372,299,418	$374,905,514
Total Charges	*$649,364,050*	*$667,010,693*	*$681,442,302*	*$686,212,398*	*$691,015,885*
Deductions from Revenue					
Deduction %	67.4%	67.4%	67.4%	67.4%	67.4%
Deductions	$437,620,842	$449,582,772	$459,447,485	$462,663,618	$465,902,263
Charity Care	$7,155,037	$7,349,477	$7,508,492	$7,561,052	$7,613,979
Total Deductions	*$444,775,879*	*$456,932,250*	*$466,955,978*	*$470,224,669*	*$473,516,242*
Bad Debt	$6,672,889	$6,856,701	$7,005,054	$7,054,090	$7,103,468
Net Patient Service Revenue	*$197,915,282*	*$203,221,742*	*$207,481,270*	*$208,933,638*	*$210,396,174*
Other Operating Revenue	*$8,189,142*	*$8,186,154*	*$8,186,154*	*$8,186,154*	*$8,186,154*
Total Operating Revenue	**$206,104,424**	**$211,407,896**	**$215,667,424**	**$217,119,792**	**$218,582,328**
Operating Expenses					
Salaries	$59,011,500	$62,077,378	$63,849,146	$64,279,335	$64,712,535
Benefits	$9,428,163	$9,931,815	$10,188,210	$10,256,843	$10,325,957
Professional Fees	$4,851,402	$4,810,190	$4,842,549	$4,875,134	$4,907,947
Supplies	$30,049,161	$31,882,360	$32,384,995	$32,603,029	$32,822,590
Purchased Services	$16,266,250	$16,776,742	$16,889,601	$17,003,250	$17,117,694
Depreciation & Amortization	$16,078,189	$16,083,675	$16,211,711	$16,325,193	$16,439,469
Interest	$15,324,402	$15,324,404	$15,431,675	$15,539,697	$15,648,474
B&O Taxes and Safety Net	$6,561,027	$6,379,943	$6,422,862	$6,466,081	$6,509,602
Other	$4,155,167	$4,840,750	$5,974,095	$6,014,744	$6,055,677
Total Operating Expenses	*$161,725,261*	*$168,107,257*	*$172,194,844*	*$173,363,305*	*$174,539,946*
Operating Margin before Allocations	*$44,379,163*	*$43,300,640*	*$43,472,580*	*$43,756,487*	*$44,042,382*
Allocations					
Corp Services Allocation	$73,190,812	$75,415,515	$78,430,381	$79,969,314	$81,538,818
Total Allocations	*$73,190,812*	*$75,415,515*	*$78,430,381*	*$79,969,314*	*$81,538,818*
Operating Income after Allocations	*($28,811,649)*	*($32,114,875)*	*($34,957,801)*	*($36,212,827)*	*($37,496,436)*
Non-operating Income					
Investment Income	$0	$0	$0	$0	$0
Foundation Unrealized Gain / (Loss)	$0	$0	$0	$0	$0
Foundation Contributions - Unrestrict	$0	$0	$0	$0	$0
Gain / (Loss) on Sale of Assets	$0	$0	$0	$0	$0
Other Non-operating Income	$0	$0	$0	$0	$0
Total Non-operating Income	$0	$0	$0	$0	$0
Net Income / (Loss)	**($28,811,649)**	**($32,114,875)**	**($34,957,801)**	**($36,212,827)**	**($37,496,436)**

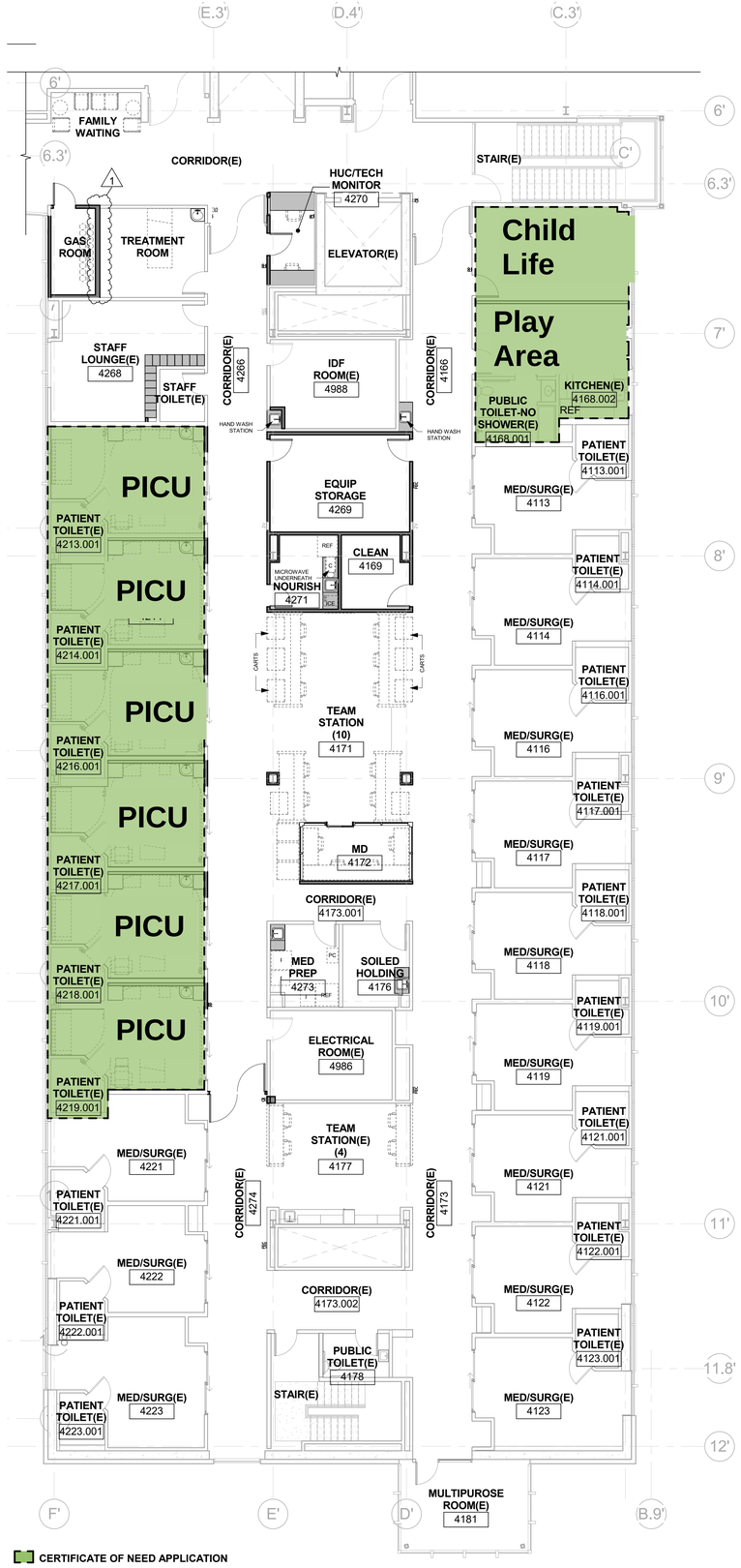
Source: Swedish Issaquah, 2018

*2019 is partial year, with September start date

Exhibit 6
Single Line Drawing of Current and Future Patient Care Floors



CURRENT LEVEL 4 MED/SURGE - CASCADE SOUTH



CERTIFICATE OF NEED APPLICATION

FUTURE LEVEL 4 PICU - CASCADE SOUTH

SWEDISH
Issaquah

Exhibit 7
Admissions Policy

Patient Rights and Responsibilities

Swedish wants you to be aware of your rights as a patient. We will do everything possible to make sure that your rights are respected.

As a patient at Swedish, you have the right:

- To request, receive or refuse visitors at your (or your representative's) discretion, unless there is a clinically necessary or reasonable restriction/limitation.
- To be treated with courtesy, dignity and respect by all hospital staff.
- To have your personal, cultural and spiritual values and beliefs supported when making a decision about treatment.
- To have someone of your choice and your physician notified promptly of your admission to the hospital.
- To talk about any complaints you have about your care without fear of getting poor treatment. To have your concerns reviewed in a timely manner with assistance or advocacy as required and, when possible, resolved in a timely manner. You have the right to be informed in writing of the response to your concerns.
- To know the name and title of your caregivers.
- To know if your care involves the training of health-care providers. You have the right to agree or refuse to participate.
- To receive complete and current information about your diagnosis, treatment and prognosis in terms you can understand. All explanations should include:
  - a description of the procedure or treatment and why it would be done
  - the possible benefits
  - the known serious side effects, risks or drawbacks
  - problems during recovery
  - the chances of success
  - other procedures or treatments that could be done
- To an interpreter or communication aid if you do not speak English, English is your second language, or you are deaf, hard of hearing, have vision issues, cognitive impairment, or have speech disabilities. Communication will be tailored to your age and your needs.
- To help your physicians and other health-care givers in the planning of your plan of care.
- To be informed of the results of treatment, positive and negative, expected or unexpected.
- To be able to receive and read your medical records in a reasonable period of time and to a description of everything in your records.
- To refuse any procedure, drug or treatment and to be informed of the possible results of your decision.
- To be free from restraint or seclusion imposed as a means of coercion, discipline, convenience, or retaliation. Restraint or seclusion will only be used to ensure the immediate physical safety of the patient, staff, or other people in the hospital, and will be discontinued as soon as your behavior no longer poses a safety threat.
- To make advance treatment directives, such as Durable Power of Attorney for Health Care and Living Wills, or Physician's Order for Life Sustaining Treatment (POLST), and to have caregivers follow your wishes. Additional information is available upon request.
- To personal privacy, to the extent consistent with your care needs. Case discussion, consultation, examination and treatment will be conducted to protect each patient's privacy.
- To know the physician who is mainly in charge of your care, as well as any physicians who might be consulting on your case.
- To have all communications and records related to your care kept confidential.
- Not to be discriminated against because of race, color, religion, sex, age, national origin, sexual orientation, disability or source of payment and other factors in admission, treatment or participation in its programs, services and activities. This statement is informed by a variety of federal and state regulations.
- To supportive care, including appropriate assessment and management of pain, treatment of uncomfortable symptoms and support of your emotional and spiritual needs, regardless of your medical status or treatment decisions.
- To receive care in a safe setting, and to be free from any forms of abuse or harassment. To access protective services.
- To request help (including family or visitor requests) from the Swedish Ethics Committee regarding ethical issues surrounding your care.

(continued)

- To be moved to another facility at your request or when medically appropriate and legally permissible. You have a right to be given a complete explanation about why you need to be moved and if there are other options. The facility to which you will be moved must first accept you as a patient.
- To know if your care involves research or experimental methods of treatment, and to be protected during research and clinical trials. You have the right to agree or refuse to participate. Refusing to participate will not prevent access to any care at Swedish.
- To be informed during your hospital stay of patient-care options when hospital care is no longer needed. You have the right to participate in planning for when you leave the hospital.
- To examine your bill and receive an explanation of the charges regardless of how you pay for your care.
- To know about hospital policies, procedures, rules or regulations applicable to your care.
- To have you or your representative make informed decisions regarding your care.
- To include family members or significant others in your care decisions.
- To have access to, request to make amendments to, and obtain information on disclosures of my health information, in accordance with applicable law.
- To be informed about unanticipated outcomes of care, treatment and services.
- To assign someone, legally, to exercise the rights listed above on your behalf, if you are unable to exercise them.

Patient Responsibilities

At Swedish, we want you to play an active role in your health care. As a patient, you have a responsibility to:

- Provide complete and accurate information about your medical history and communication needs to those involved in your care.
- Take part in decisions about your care and treatment.
- Ask questions about unfamiliar practices and procedures.
- Inform your physician or nurse of any changes in your health.
- Follow your treatment plan of care.
- Be considerate of other patients and ensure that your visitors are equally thoughtful.
- Respect hospital policies and staff.
- Arrange payment methods prior to your hospitalization.
- Be respectful of your caregivers and obey hospital regulations; this will help us provide you with a safe environment where we can give you the best care possible. In rare instances where patients jeopardize our safe environment and can't respect our employees, the physician is notified and discharge may occur.

Comments or Concerns

There is a complaint procedure in which patients may participate without fear of jeopardizing their care. If you have concerns or complaints about any part of your care at Swedish, please feel free to speak with any manager or staff member on the unit or in your clinic. You may also contact:

Swedish Medical Center (First Hill, Ballard, Cherry Hill, Issaquah, Ambulatory Care Centers – Mill Creek, Redmond)
Clinical Patient Relations (clinical-care issues)
747 Broadway
Seattle, WA 98122-4307
206-386-2111 or ext. 62111 (from an in-house phone)

Swedish Medical Center/Edmonds Campus
Patient Advocate
21601 76th Ave. W.
Edmonds, WA 98026
425-640-4365
DL-PatientAdvocate-EDM@swedish.org

Swedish Medical Group (clinics)
Direct concerns to the Clinic Manager
Nurse Executive: 206-320-4924

In addition, you also have the right to contact the Washington State Department of Health or the Joint Commission Office of Quality Monitoring.

Washington State Department of Health
Facilities and Service Licensing
Attention: Investigations
P.O. Box 47852
Olympia, WA 98504-7852
1-800-633-6828

Office of Quality Monitoring
The Joint Commission
One Renaissance Blvd.
Oakbrook Terrace, IL 60181
1-800-994-6610
complaint@jointcommission.org

If you are a Medicare beneficiary and have a complaint regarding quality of care, your Medicare coverage, or premature discharge, you may contact Qualis Health at the following address:

Qualis Health
10700 Meridian Ave. North
Seattle, WA 98133
1-800-445-6941

SWEDISH

www.swedish.org

SU-07-07474 (397388-NOT STOCKED) R-10/13

Our Policy

- We respect the rights and responsibilities of patients to make choices about their health care, including decisions regarding withholding or withdrawing life-sustaining treatment.
- We are committed to providing you with health-care treatment information and listening to your treatment choices. You have the right to accept or refuse any medical treatment.
- We will not discriminate against anyone based on whether or not the person has written an Advance Directive.
- We will honor treatment decisions stated in your Advance Directives, except where we believe it is not medically indicated or unethical to do so. If the medical center or doctor cannot honor your Advance Directive based on the above policies, we will make every effort to transfer you to a facility that will.

SWEDISH

www.swedish.org

ADMN-13-12500 2/13

Advance Care Planning

SWEDISH

Planning Ahead

Every day, people face unexpected medical problems affecting themselves or those close to them. Sometimes critical decisions must be made quickly. Most of us expect and wish to have control over our own medical care, but we may become so sick that we cannot speak for ourselves.

Even if you never need others to make decisions for you, it may help you and your loved ones to think ahead about end-of-life care. These kinds of decisions are difficult and painful to make. Each of us has our own idea about what makes life good and the decisions are usually easier to make if we have had discussions together and know what each one of us considers most important.

Take time to think about these possibilities before a crisis happens. This will help you decide what is really important to you. While talking about things with your family, you may learn what is important to them, too.

It may be helpful to consider some of the following:

- How much medical treatment do you want if you have an injury or illness, which could cause death or leave you disabled?
- Would you choose to refuse treatments that seem to prolong the dying process?
- How do you feel about being dependent on machines to stay alive? Would you choose mechanical support for a brief period, if you could become independent again later?

The answers to these questions are not easy, but talking about them with others will help you and them to understand your preferences. It may also be easier on your family later if they believe they are following your wishes.

Check Your Options

Living Will & Durable Power of Attorney for Health Care

There is a way you can put your wishes in writing now through an *Advance Directive*.

Advance Directives are legal documents where you write down how you want your health care handled if you can no longer make or communicate decisions. There are two kinds of Advance Directives: *Living Will* and *Durable Power of Attorney for Health Care*.

A **Living Will** generally states the medical care you want or do not want if you become ill and are unable to make your own decisions. It is not possible to plan for every potential situation, but the Living Will lets you say in general terms how you would want to be cared for. Two people will have to witness your signature on the Living Will. They cannot be related to you and they cannot work for your doctor or the hospital.

A **Durable Power of Attorney for Health Care** names another person to make medical decisions for you if you are unable to speak for yourself. That person could be a relative, friend, significant other, or anyone you choose.

It should be the person who has the greatest understanding of what you value and what gives meaning to your life, and who would be willing to make decisions for you at a very difficult time.

Should your wishes change, you may change or cancel any of your advance planning documents. It is very important to make sure your family and your doctor know when you have completed or changed your documents. These changes or additions need to be in writing and dated.

If you choose to revoke any of your advance directives while receiving care, you may tell your doctor verbally who then must document the changes in your medical record.

If you have not named someone as your Durable Power of Attorney for Health Care, then, by law, the following people (in the order noted below) would be the ones to decide for you.

1. Your spouse or legal domestic partner; if none then:
2. Your adult children (at least 18 years of age; decision must be unanimous if more than one child); if none then:
3. Your parents (decision must be unanimous); if none then:
4. Your adult brothers and sisters (decision must be unanimous).

POLST: Physician Orders for Life-Sustaining Treatment

Complementing your advance directive(s), you may wish to have a physician order to address serious health conditions in emergency situations.

A POLST form is recommended for any individual with an advanced, lifelimiting illness or chronic frailty. If you have a serious health condition, you should make decisions about life-sustaining treatment. Your physician can use the POLST form to represent your wishes as clear and specific medical orders that indicate what types of life-sustaining treatment you want or do not want at the end of life. These orders will be followed in whatever setting you are in: nursing home, aid car, home or hospital. The POLST form asks for information about:

- Your preferences for resuscitation
- Medical interventions
- The use of antibiotics
- Artificially administered fluids and nutrition

Organ/Tissue Donation

You may want to donate your organs and/or tissues after your death, to help provide life for someone in need. Up to 50 lives can be saved or enhanced by a single donor. Everyone is a potential donor. Do not rule yourself out for age, medical condition, or diagnosis, as a medical assessment will take place at the time of donation.

If you wish to donate your organs and/or tissues, you will need to register. This can be done when you renew your driver's license. Or you may register online at **www.donatelifetoday.com**.

This is a very personal decision, which will be easier for your family to honor if they know your wishes. If you decide to be a donor, be sure to discuss your decision with your family, doctor and friends.

For additional resources, including downloadable forms, go to **www.swedish.org**, **www.wsma.org** or **www.wsha.org**. Use the search term "POLST" or "Advance Directives" to access more details on each of these topics.

SWEDISH MEDICAL CENTER

CONDITIONS OF ADMISSION FORM AND CONSENT

Administrative Procedure	
Approved: May 2013	Next Review: May 2016
Department: All patient access areas, all clinical units	
Population Covered: All patients	

Related Policies/Procedures:

Advance Directive and CPR Preference
Patient Health Information: Assigning Next-of-Kin
Patient Rights
Using Health Care Agreements for Behavioral Management: Patient

Purpose

To ensure the standard *Conditions of Admission* (COA) form is appropriately communicated and signed by the patient or their representative at time of admission to Swedish Medical Center. The COA form serves as the initial consent for treatment at Swedish Medical Center and other consents may be obtained depending on the context of care.

Policy Statement

Written consent is necessary prior to any non-emergent treatment or procedure. All facility admissions require the COA form signed by the patient or his/her representative at the time of each hospital outpatient visit or bedded admission encounter. For recurring outpatient accounts, this form is required to be obtained at the initial visit of the treatment plan and/or after periods of more than 90 days between services for ongoing treatment.

The contents of the COA form are reviewed by patient registration staff members with the patient and/or the patient's representative during the admission process. The patient's or his/her representative's signature is obtained confirming his/her consent for care, understanding of his/her rights and expectations as a patient at Swedish, knowledge of billing information, and awareness that a *Notice of Health Information Practices* is available at registration or upon request. The patient or his/her representative may be referred to appropriate administrative or clinical staff with questions about the COA form. **Changes to the COA form are not permitted.**

Patient Registration staff members are responsible for explaining the contents of *Conditions of Admission* form, affixing patient label to the form, obtaining appropriate signatures, and scanning the form into the electronic medical record (EMR) once signed.

In the event a signature cannot be obtained during an emergent or direct admission, staff members will witness the initial COA, document 'Unable to Obtain Signature' reason, and follow up with clinical care unit to ensure that each patient medical record contains a signed *Conditions of Admission* form.

Patient Registration.

PROCEDURE	
Responsible Person	Steps
Patient Registration Staff	**OBTAINING CONSENT FOR COA FORM** *The following steps are performed at the time of registration. These steps may also be performed on the unit if the patient is admitted directly to a room.* 1. During admission, a Patient Registration staff member reviews the *Conditions of Admission* form with the patient or the patient's representative. **Points to emphasize during COA review:** • Notification of **Patient Rights** information is posted in the admission department and a flyer is also available for the patient/representative to keep. • CPR will be performed in the event of an emergency unless there is a physician order in the electronic medical record (EMR) directing otherwise. • Medical information may be disclosed to designated insurance plans or entities to receive payment for services. • Financial assistance is available to those who qualify. • The patient may receive bills from other providers associated with his or her care at a Swedish facility. • The *Notice of Health Information Practices* is available at admission or upon request. • Changes to the COA form are not permitted. 2. The patient or his/her representative signs the COA form. **IF NO SIGNATURE CAN BE OBTAINED AT ADMISSION** 1. If the patient is unable to sign upon an emergent or direct admission, Patient Registration staff contacts the patient's representative for consent (written or verbal) and documents accordingly using **HAR Account Note** in EMR. 2. If no representative can be reached at admission, then Patient Registration staff or clinical unit staff member signs and dates the COA form as witness, documenting "Unable to Obtain Signature" reason. 3. Patient Registration staff makes multiple attempts to communicate the COA form and has the patient sign and/or reach his/her representative for signature. Attempts are documented using **HAR Account Note** in the EMR. a. During the attempts process, Patient Registration withholds the COA from scanning into EMR and continues to seek a signature until such time the patient is discharged. If patient is discharged without COA signed, clinical information in the chart should reflect the urgency of the admission and the patient's inability to receive COA communication throughout his/her encounter. b. Registration staff may also seek assistance of the clinical unit staff to help obtain the COA signature.

Definitions

None.

Forms

Conditions of Admission (Standard Form #60337)

Supplemental Information

Washington State Hospital Association (WSHA) Requirements for Valid Signed Conditions of Admissions Consents:

- Identification of the patient to include patient name and medical record number
- Name of hospital in which treatment is to be performed
- Date and time
- Signature of patient or patient's representative
- Written legibly in ink
- Witnessed by employee(s) of the hospital in which the consent is obtained

Patient's Agent or Representative

- The following persons may sign the consent on behalf of the patient (listed in priority order):

  1) Appointed guardian
  2) Individual to whom the patient has given a Durable Power of Attorney encompassing the authority to make healthcare decisions
  3) Patient's spouse or state registered domestic partner
  4) Patient's children who are at least eighteen (18) years of age
  5) Patient's parents
  6) Patient's adult brothers and sisters.

- Verbal consent may be given and must be documented on the *Conditions of Admissions*. The *Conditions of Admissions* is to be signed by two witnesses if verbal consent is necessary or if the patient is unable to sign and his/her representative is unavailable.

Regulatory Requirements

RCW 7.70.060 – Consent Form / Contents / Use.
RCW 7.70.065 – Informed consent – Persons authorized to provide for patients who are not competent.

References

WSHA Consent Manual, Chapter V.

Summary of Services that can be Provided to Minors without Parental Consent – State of Washington.

Addenda

Notice of Health Information Practices
Patient Rights and Responsibilities

STAKEHOLDERS

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Sponsor

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Exhibit 8
Charity Care Policy

SWEDISH

FINANCIAL ASSISTANCE – CHARITY CARE

Administrative Policy	
Approved: Pending (12/2015)	**Next Review:** January 2017
Department: All Swedish Hospital Facilities, Departments and Clinics	
Implementation Date: January 1, 2016	

Purpose

The purpose of this policy is to set forth Swedish Health Services (SHS)'s Financial Assistance Policy (FAP), which is designed to promote access to medically necessary care for those without the ability to pay, and to offer a discount from billed charges for individuals who are able to pay for only a portion of the costs of their care. This programs apply solely with respect to emergency and other medically necessary healthcare services provided by SHS.

Responsible Persons

Revenue Cycle departments

Policy

It is both the philosophy and practice of SHS that medically necessary healthcare services are available to community members and those in emergent medical need, without delay, regardless of their ability to pay. For purposes of this policy, "financial assistance" includes charity care and other financial assistance programs offered by SHS.

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

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

3. SHS will provide financial assistance to qualifying patients or guarantors in a respectful, compassionate, fair, consistent, effective and efficient manner.

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

5. In extenuating circumstances, SHS may at its discretion approve financial assistance outside of the scope of this policy. Uncollectible/presumptive charity is approved due to but not limited to the following: social diagnosis, homelessness, bankruptcy, deceased with no estate, history of non-

compliance and non-payment of account(s). All documentation must support the patient/guarantors inability to pay and why collection agency assignment would not result in resolution of the account.

6. SHS hospitals with dedicated emergency departments will provide, without discrimination, care for emergency medical conditions (within the meaning of the Emergency Medical Treatment and Labor Act (EMTALA) consistent with available capabilities, regardless of whether an individual is eligible for financial assistance. SHS hospitals will provide emergency medical screening examinations and stabilizing treatment, or refer or transfer an individual if such transfer is appropriate in accordance with 42 C.F.R. 482.55. SHS prohibits any actions that would discourage individuals from seeking emergency medical care, such as by permitting debt collection activities that interfere with the provision of emergency medical care.

Providers Subject to SHS's FAP

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

Financial Assistance Eligibility Requirements

Financial assistance is available for both uninsured and underinsured patients and guarantors where such assistance is consistent with federal and state laws governing permissible benefits to patients. Financial assistance is available only with respect to amounts that relate to emergency or other medically necessary services. Patients or guarantors with gross family income, adjusted for family size, at or below 400% of the Federal Poverty Level (FPL) are eligible for financial assistance, so long as no other financial resources are available and the patient or guarantor submits information necessary to confirm eligibility.

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

- Proof of application to Medicaid may be requested.

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

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

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

The SHS service area is defined as any Washington counties serviced by the SHS hospital.

Eligibility for financial assistance shall be based on financial need at the time of application. All income of the family as defined by Washington law governing charity care [1] is considered in determining the applicability of the SHS sliding fee scale in Attachment B. Patients seeking financial assistance must provide any supporting documentation specified in the application for financial assistance, unless SHS indicates otherwise.

[1] "Income" and "family" are defined in WAC 246-453-010(17)-(18).

Basis for Calculating Amounts Charged to Patients Eligible for Financial Assistance

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

- **100 Percent Discount/Free Care:** Any patient or guarantor whose gross family income, adjusted for family size, is at or below 300% of the current federal poverty level (FPL) is eligible for a 100 percent discount off of total hospital charges for emergency or medically necessary care, to the extent that the patient or guarantor is not eligible for other private or public health coverage sponsorship.[2]

- **Discounts Off Charges at 75 Percent :** The SHS sliding fee scale set forth in Attachment B will be used to determine the amount of financial assistance to be provided in the form of a discount of 75 percent for patients or guarantors with incomes between 301% and 400% of the current federal poverty level after all funding possibilities available to the patient or guarantor have been exhausted or denied and personal financial resources and assets have been reviewed for possible funding to pay for billed charges. Financial assistance may be offered to patients or guarantors with family income in excess of 400% of the federal poverty level when circumstances indicate severe financial hardship or personal loss.

- **Limitation on Charges for all Patients Eligible for Financial Assistance**: No patient or guarantor eligible for any of the above-listed discounts will be personally responsible for more than the "Amounts Generally Billed" (AGB) percentage of gross charges, as defined in Treasury Regulation Section 1.501(r)-1(b)(2), by the applicable SHS hospital for the emergency or other medically necessary services received. SHS determines the applicable AGB percentage for each SHS hospital by multiplying the hospital's gross charges for any emergency or medically necessary care by a fixed percentage which is based on claims allowed under Medicare. Information sheets detailing the AGB percentages used by each SHS Hospital, and how they are calculated, can be obtained by visiting the following website: www.swedish.org or by calling: **1-877-406-0438** to request a paper copy. In addition, the maximum amount that may be collected in a 12 month period for emergency or medically necessary health care services to patients eligible for financial assistance is 20 percent of the patient's gross family income, provided that the patient remains eligible for financial assistance under this policy throughout the 12-month period.

Method for Applying for Assistance and Evaluation Process:

Patients or guarantors may apply for financial assistance under this Policy by any of the following means: (1) advising SHS's billing office staff at or prior to the time of discharge that assistance is requested, and submitting an application form and any documentation if requested by SHS; (2) downloading an application form from SHS' website, at: www.swedish.org, and submitting the form together with any required documentation; or (3) requesting an application form by telephone, by calling: **1-877-406-0438**, and submitting the form with any required documentation. SHS will display signage and information about its financial assistance policy at appropriate access areas. Including but not limited to the emergency department and admission areas.

The hospital will give a preliminary screening to any person applying for financial assistance. As part of this screening process SHS will review whether the person has exhausted or is ineligible for any third-party payment sources. SHS may choose to grant financial assistance based solely on an initial determination of a patient's status as an indigent person, as defined in WAC 246-453-010(4). In these cases, documentation may not be required. In all other cases, documentation is required to support an application for financial assistance. This may include proof of family size and income and assets from any source, including but not limited to: copies of recent paychecks, W-2 statements, income tax returns, forms approving or denying Medicaid or state-funded medical assistance, forms approving or denying unemployment compensation, written statements from employers or welfare agencies, and/or bank statements showing activity. If adequate documentation cannot be provided, SHS may ask for additional

[2] *See* RCW 70.170.060 (5).

information.

A patient or guarantor who may be eligible to apply for financial assistance may provide sufficient documentation to SHS to support an eligibility determination until fourteen (14) days after the application is made or two hundred forty (240) days after the date the first post-discharge bill was sent to the patient, whichever is later per the 501(r) regulations. SHS acknowledges that per the WAC 246-453-020(10), a designation can be made at any time upon learning that a party's income is below 200% of the federal poverty standard. Based upon documentation provided with the application, SHS will determine if additional information is required, or whether an eligibility determination can be made. The failure of a patient or guarantor to reasonably complete appropriate application procedures within the time periods specified above shall be sufficient grounds for SHS to determine the patient or guarantor ineligible for financial assistance and to initiate collection efforts. An initial determination of potential eligibility for financial assistance will be completed as closely as possible to the date of the application.

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

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

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

Billing and Collections

Any unpaid balances owed by patients or guarantors after application of available discounts, if any, referred to collections in accordance with SHS's uniform billing and collections policies. For information on SHS's billing and collections practices for amounts owed by patients or guarantors, please see SHS's Bad Debt Collection Policy, which is available free of charge online at: www.swedish.org; or which can be sent to you if you call: **1-877-406-0438**.

Definitions

None.

Supplemental Information

None.

Regulatory Requirement

Section 1867 of the Social Security Act
Section 501(r) of the Internal Revenue Code
RCW 70.170.060
WAC Ch. 246-453

References

None.

Addenda

Charity Care Percentage Sliding Fee Scale

STAKEHOLDERS

Author/Contact

Iris Mireau, Customer Service Manager

Expert Consultants

Swedish/Providence Legal Services

Sponsor

Elise Myers, System Director, Revenue Cycle

ATTACHMENT A
Hospital-Based Providers Not Subject to SHS's Financial Assistance Policy and Associated Discounts

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

ATTACHMENT B

Discounts Available Under SHS's Financial Assistance/Charity Care Policy

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

For guarantors with income and resources above 300% of the FPL the SHS sliding fee scale below applies.

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

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

Assets considered for evaluation; IRAs, 403(b) accounts, and 401(k) accounts are exempt under this policy, unless the patient or guarantor is actively drawing from them. For all other assets, the first $100,000 is exempt.

Income and assets as a percentage of Federal Poverty Guideline Level	**Percent of discount (write-off) from original charges**	**Balance billed to guarantor**
100-300%	**100%**	**0%**
301-400%	**75%**	**25%**

Exhibit 9
Letter of Reasonableness – Contractor Cost Estimate

ANDERSEN
CONSTRUCTION

August 27, 2018

Dear Heidi,

Based on our experience building projects of similar size and scope, we feel that the construction cost estimate of $290,000 for the tenant improvement of the PICU remodel at Swedish Issaquah Washington is within the expected range of construction costs.

Sincerely,

Craig A. Holt

Project Executive

Andersen Construction

Exhibit 10
Letter of Financial Commitment

SWEDISH

August 27, 2018

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

RE: Swedish Health Services, Certificate of Need Application for a Six Bed Pediatric Intensive Care Unit at Swedish Issaquah

Dear Ms. Sigman:

Please accept this letter as evidence of financial support for Swedish Health Services ("Swedish") for its certificate of need application.

Swedish is pleased to commit from its corporate reserves for funding the $290,000 in capital expenditures required for the proposed project to convert six existing acute care beds into six pediatric intensive care (PICU) beds at Swedish Issaquah. Swedish has sufficient cash reserves to fund this project.

Sincerely,

Sheri Feeney
Chief Financial Officer
Swedish Health Services

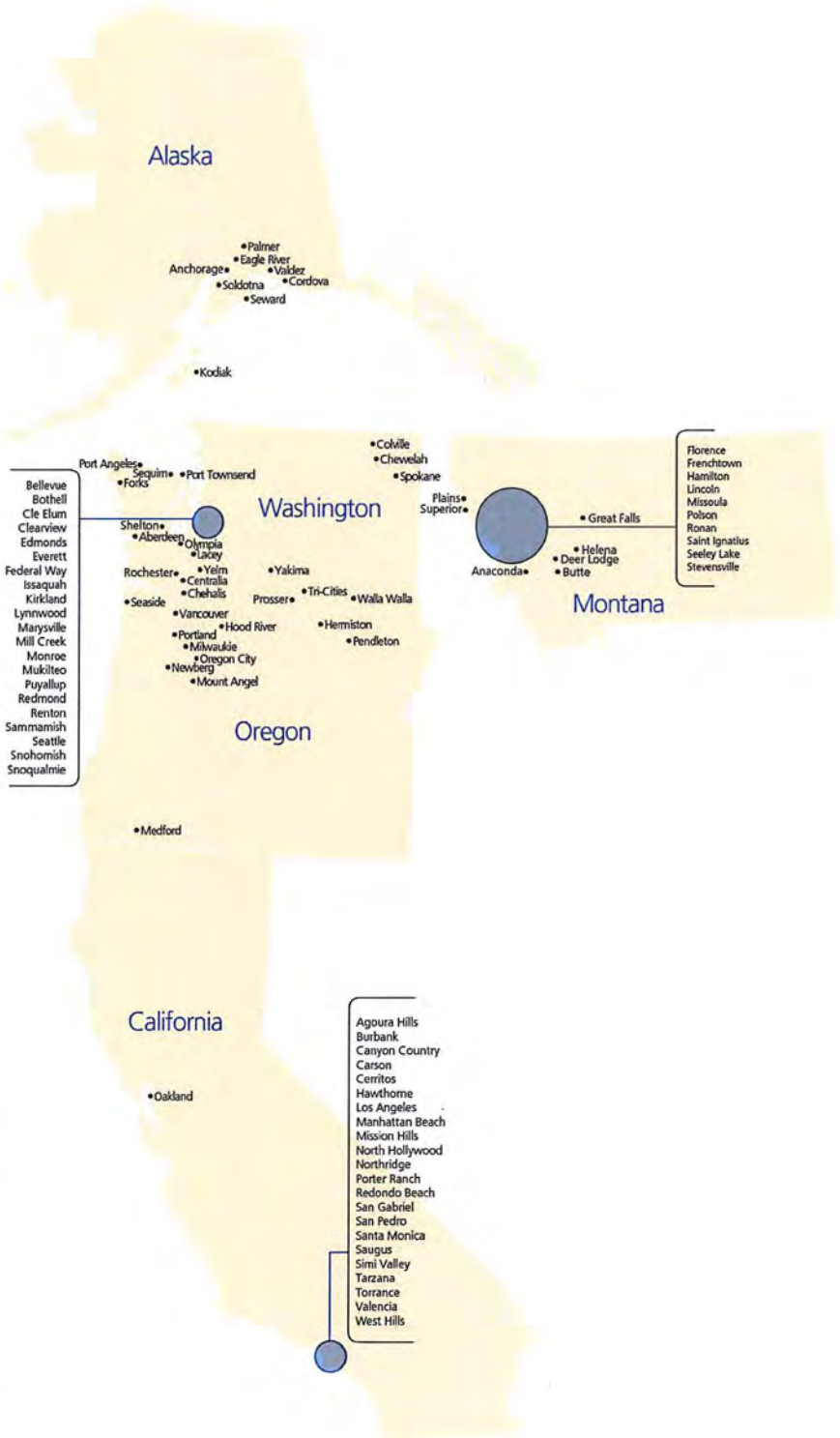
Exhibit 11
Providence Health & Services
Audited Financials, 2015
&
Providence St. Joseph Health
Audited Financials, 2016-2017

PROVIDENCE
Health & Services

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

Year ended December 31, 2015

Todd Hofheins, Executive Vice President and Chief Financial Officer



The care and services Providence delivers spans from birth to hospice, to care for the whole person. Our comprehensive scope of services includes acute care, physician clinics, long term and assisted living, palliative and hospice care, home health, education and supportive housing. Our ministries are in Alaska, California, Montana, Oregon and Washington with our system office located in Renton, Washington.

PROVIDENCE
Health & Services

Introduction to Management's Discussion and Analysis

Management's discussion and analysis provides additional narrative explanation of the financial condition, operational results and cash flow of Providence Health & Services (Providence) to increase understanding of the health system's combined financial statements. The discussion and analysis should be read in conjunction with the accompanying audited combined financial statements.

Creating healthier communities, together

As health care evolves, Providence is responding with a vision and core strategy to transform and innovate at scale. Across five states, Providence and its affiliates continue to pioneer how care is delivered by sharing one strategic plan designed to improve the health of entire populations by supporting the well-being of each person we serve. Our core strategy of "*Creating healthier communities, together*" is supported by five specific areas of focus in our strategic plan:

- Inspire: We must first inspire and develop our people.
- Know: To serve our communities effectively, we are building enduring relationships with consumers.
- Partner: Providing the best care requires new alignments with clinicians and care teams.
- Adapt: We'll develop and thrive under new care delivery and economic models.
- Adopt: To serve more people we will grow by optimizing expert-to-expert capabilities.

This plan supports our vision, "Together, we answer the call of every person we serve: Know me, care for me, ease my way ®," which is our promise to our patients, customers and communities. Through innovation, excellence, good stewardship and working together across Providence, we will continue to lead change to improve the health of our communities.

Investing in our communities to improve health and increase access

With strong support from Providence, Alaska launched Medicaid expansion in 2015 and Montana began expansion early in 2016, ensuring that all five of our states have increased eligibility under the Affordable Care Act. In an environment of decreased reimbursement for government-sponsored medical care, community benefit spending related to the unpaid costs of Medicaid was $538 million in 2015 compared with $444 million in 2014. Providence cares for everyone, regardless of their ability to pay. In 2015 we provided more than $951 million in community benefit, which increased over $100 million from 2014.

Providence had a strong impact on landmark new payment codes that recognize the value of advance care planning by reimbursing clinicians for having these discussions with their patients. The Centers for Medicare and Medicaid Services adopted recommendations developed by Providence and our partners that advance care planning be added as an optional, separately billable, element of the annual wellness visit. Going into effect in 2016, these codes will be instrumental for Providence, other Catholic ministries, and other providers that are committed to whole-person care models.

Together, we answer the call of every person we serve: Know me, care for me, ease my way.

Collaborating with like-minded partners

St. Joseph Health System

Providence and St. Joseph Health continue to work through the process of bringing our organizations together after signing a letter of intent in July 2015 and a definitive agreement in November 2015 to create a new single organization. Closure of the transaction is dependent on the timing of regulatory review, which we now estimate will be complete in the second quarter of 2016.

The two Catholic health systems, with long histories of serving communities in the American West, plan to create a new parent organization, Providence St. Joseph Health, that will focus on a shared mission and vision, as well as the strategic, financial and operational direction for the system overall. Dr. Rod Hochman will serve as the CEO of the parent organization, which will be based in Renton, Wash. There will be two system offices - in Renton and in Irvine, Calif. The board of directors of the parent organization will include seven members appointed by Providence and seven members appointed by St. Joseph Health.

"Together, we can invest more in the needs of everyone we serve, especially the most vulnerable,"
-Rod Hochman, M.D., President and CEO

Walgreens

As part of our commitment to creating healthier communities together, Providence is collaborating with Walgreens to open 25 clinics in Walgreens stores in Oregon and Washington during the next two years, starting with six clinics in Portland and Seattle opening in February 2016. In Portland, the clinics will be operated by Providence, staffed by Providence providers, and called Providence Express Care at Walgreens and in the Seattle area will be operated by Swedish, staffed by Swedish providers, and called Swedish Express Care at Walgreens. This program is another way we are answering the call of every person we serve. Current patients will experience a seamless patient experience through our existing electronic health record system, providing direct connectivity to the clinics and billing systems which will ensure better continuity of patient care and collaboration among providers.

Greater Fairbanks Community Hospital Foundation

Providence has signed a letter of intent with the Greater Fairbanks Community Hospital Foundation to pursue a lease agreement under the secular entity Western HealthConnect. The agreement would cover operations for Fairbanks Memorial Hospital, Denali Center and Tanana Valley Clinic. Fairbanks Memorial Hospital has 152 licensed beds and has served the community for more than 40 years.

The Hospital Foundation began a search for a new lease agreement partner after deciding not to renew a 15-year affiliation with Arizona-based Banner Health. Providence is honored to be selected as their proposed new partner and look forward to working with the Hospital Foundation to create healthier communities, together. We are excited to continue this tradition and to return to the Fairbanks community, where we served from 1910 to 1968.

As part of the letter of intent, we will negotiate a transition lease - under essentially the same terms as Banner - with the intent to negotiate a multi-year lease in the future. The lease agreement will be with Western HealthConnect, the entity formed to allow Providence to remain Catholic and secular affiliates to

remain secular. This is the same model we used for our affiliations with Swedish, Pacific Medical Centers and Kadlec.

Leading dynamic change through innovation

Population Health

Population health will be a critical part of achieving Providence's strategy of creating healthier communities, together. Our goal is to maximize the health outcomes of the people in our defined populations and communities through the design, delivery and coordination of affordable quality health care. We are focused on the customer experience, while driving operational and financial excellence though our innovation in this space.

Consumer Health Engagement and Support

Our innovation team is developing tools and services that engage consumers to keep them healthy between episodes of care. For example, we will test a new service line for our 65 and over population that aims to increase the options seniors have in the choice to safely age in place in their homes and defer the stress and costs of a move to a long term care facility. The program will partner with our clinics to support day to day living tasks like meal delivery and transportation, improve the safety of a senior's home, and provide trusted planning and advice about aging optimally.

Leadership in the Healthcare Industry

Rod Hochman, M.D., president and chief executive officer, was recently appointed to the Board of Trustees for the Catholic Health Association of America.

Mike Butler, president, operations and services, has joined the Board of Directors of Medical Teams International.

Amy Compton-Phillips, M.D., executive vice president and chief clinical officer, along with **Rhonda Medows**, M.D., executive vice president of population health, were recently listed in Becker's Hospital Review annual list of influential female leaders in health care.

Providence ExpressCare

In order to provide health care to our patients on their own terms through a diverse range of care delivery offerings, Providence has launched ExpressCare, where patients can receive primary care in a retail setting. In addition to twenty-five ExpressCare Walgreens-embedded clinics, twenty-five standalone retail clinics will be opening throughout Washington, Oregon, California, and Montana in 2016 and 2017. ExpressCare clinics will be equipped with in-clinic "Appointments Now Available" monitors, website registration and scheduling, as well as walk-in kiosks with scheduling, check-in, and registration. ExpressCare will also be supported by a mobile app with clinic search, scheduling, registration and MyChart access as well as integrated telehealth.

Telehealth

Significant progress was made on our 2015 priorities including: iterating on and rolling out a new B2B technical infrastructure, turning on self-service features, accelerating deployment velocity and efficiency, and developing capabilities to be able to deploy easily to new service lines. We have developed a fully integrated platform that will effectively support both expert-to-expert telehealth as well as direct to consumer telehealth. Priorities for 2015 included improving quality of communication for clinicians and

patients, reduced cost and accelerated deployment, safe and easy self-service features, and developing capabilities to be able to deploy easily to new service lines. The expert-to-expert telehealth platform for Telestroke was launched in 43 locations, while the Telehospitalist program completed a successful pilot and is now being deployed more broadly. HealthExpress, our $39 urgent care telehealth offering is now available in Washington and Oregon. Visit http://healthexpress.com to learn more.

Providence Milestones

- Named as one of the 'Most Wired' organizations in health care by the American Hospital Association.
- Ranked 153 of 500 on the Forbes list of America's Best Employers in 2015.
- The power of our Mission continues to shine through in a recent survey with 92 percent of caregivers (all employees) agreeing with the statement, "My work supports the Mission."

Financial Performance

Year-end Results

Key Financial Indicators *Data is year-to-date; dollar figures presented in millions*	2015	2014	Organic Growth*
Net Operating Income	$262	$219	$233
Net Income	$77	$771	$44
EBIDA	$864	$1,133	$807
Total Community Benefit	$951	$848	$931
Operating Margin %	1.8%	1.8%	1.7%
Accounts Receivable Days	47	50	48
Days of Cash on Hand	159	183	163
Long-term Debt to Total Capitalization	33.8%	33.8%	33.3%
Cash to Debt	138.1%	130.9%	148.2%

** Reflects 2015 year-to-date results from entities that have been affiliated with Providence for more than 12 months.*

Operating income increased by 19.5 percent over the prior year, growing from $219 million in 2014 to $262 million in 2015. Operating margin remained consistent with the prior year at 1.8 percent while revenues continued to increase in 2015. Total net service revenue grew 16.7 percent or $1.7 billion over the prior year from $10.1 billion in 2014 to $11.8 billion in 2015 driven by higher volumes and the recognition of revenue from state provider tax programs.

While operating income experienced positive growth in 2015, annual investment performance had a negative impact on Providence's net income and earnings before interest, depreciation, amortization and affiliation gains (EBIDA) as a result of challenging market conditions. Total investment losses for the year were $114 million as compared to $178 million in positive investment income in 2014. As a result, net income for the twelve months ended December 31, 2015 was $77 million as compared to $771 million in the prior year. Net non-operating income, excluding investment income, was -$71 million in 2015 compared to $374 million in 2014. The 2015 non-operating income was primarily impacted by pension settlement costs, while 2014 was benefited from affiliation related gains, partially offset by extinguishment of debt and pension settlement costs. EBIDA was $864 million in 2015 as compared to $1,133 million in 2014.

Several of the states we serve operate broad-based provider tax programs to fund the non-federal share of Medicaid. Providence recorded net operating income of $84 million during the twelve months of 2015 related to these programs, compared to no related revenue in the prior year. Timing of program approval by regulating agencies can impact the timing of recognizing related income, and as a result, approximately $50 million of the provider tax income recorded in 2015 related to services provided in 2014.

Liquidity & Capital

Unrestricted cash reserves totaled $5.8 billion as of December 31, 2015 compared to $6.0 billion as of December 31, 2014. The decrease was primarily driven by investment losses, capital purchases, and debt payments made during the year, partially offset by cash generated from operations.

Days cash on hand (DCOH) decreased 24 days from 183 days on December 31, 2014 to 159 days on December 31, 2015. This decline was driven by a combination of factors. First, a reduction in cash reserves primarily driven by investment losses. Second, patient volume growth led to higher operating revenues and corresponding expenses year over year.

Volumes

Key Volume Indicators *Data is year-to-date; presented in thousands unless noted*	2015	2014	Organic Growth*
Inpatient Admissions	362	333	353
Acute Adjusted Admissions	651	602	633
Total Emergency Room Visits	1,457	1,332	1,411
Total Surgeries	244	227	238
Continuum Services Visits	2,319	2,272	2,319
Physician Care Visits	7,742	6,881	7,443
Connected Lives - Member Months	6,050	5,147	6,050
Observations	56	58	56
Rate - Net Service Revenue/CMAA (whole value)	$12,295	$11,499	$12,299
CMI Adjusted Length of Stay (whole value)	2.9	2.9	2.9

** Reflects 2015 year-to-date results from entities that have been affiliated with Providence for more than 12 months.*

Providence's continued investment in our communities and strategy of collaborating with like-minded partners led to higher acute setting volumes in 2015. Year-to-date inpatient admissions of 362 thousand were 29 thousand or 8.7 percent higher than the prior year. Year-to-date surgeries of 244 thousand were 17 thousand higher than prior year, which represented a 7.3 percent increase. Surgery counts increased in both inpatient and outpatient categories with inpatient increasing 8.7 percent and outpatient increasing 6.1 percent in 2015 as compared to 2014. Emergency visits were 125 thousand visits or 9.4 percent higher in 2015.

Strategic focus and innovations in clinical and home based care led to growth in these categories in 2015. Physician visits of 7,742 thousand were 861 thousand visits higher than the prior year, an increase of 12.5

percent. Continuum services, which include long term care, hospice, housing, assisted living and home health, generated 2,319 thousand visits year-to-date, which was 2.1 percent higher than the prior year.

The Providence Health Plan has continued to expand its services in the changing coverage landscape. Connected lives member months, a measure of coverage for insured members, increased from 5,147 member months in 2014 to 6,050 member months in 2015. This growth in member coverage represented a 17.5 percent increase compared to the prior year. Enrolled members, including Administrative Services Only (ASO) members, grew 17 percent from 437 thousand in December 2014 to 513 thousand in December 2015.

Revenue

Operating Revenue *Data is year-to-date; figures presented in millions*	2015	2014	Organic Growth*
IP Net Service Revenue	$ 6,386	5,306	6,235
OP Net Service Revenue	3,381	3,145	3,252
Primary Care	1,486	1,232	1,465
Continuum Services	715	612	715
Capitated & Premium Revenue	1,862	1,683	1,814
Bad Debt	(186)	(193)	(179)
Other Revenue	790	696	781
Total Operating Revenue	**$ 14,434**	**12,481**	**14,083**

** Reflects 2015 year-to-date results from entities that have been affiliated with Providence for more than 12 months.*

Year-to-date operating revenue of $14.4 billion was $2.0 billion or 15.6 percent greater than prior year. Revenue included $612 million from provider tax related programs, of which $240 million was related to the prior year. Payments related to 2014 were recorded in 2015 due to the timing of program approvals from state agencies that administer the provider fee programs. Capitated revenue of $399 million was 17.6 percent higher than the prior year as a result of growth in our accountable care organizations. Total premium revenue of $1,464 million was 8.9 percent higher as membership in the Providence Health Plans expanded in 2015. Premium revenue grew at a slower rate than enrollments primarily due to a change in product mix from 2014 to 2015, which saw a general shift towards more high deductible plans. Capitated and premium revenue represented 13 percent of Providence's total operating revenue, in line with the prior year.

Since 2012 Providence has participated in federal programs designed to provide incentive funding to hospitals and providers that implement electronic health record systems. Providence recorded $22 million in revenue in 2015 related to this meaningful use funding, which was lower than the $55 million recorded in 2014. This year-over-year decrease was expected as most providers and hospitals near the end of the three year incentive program.

Operating Expenses

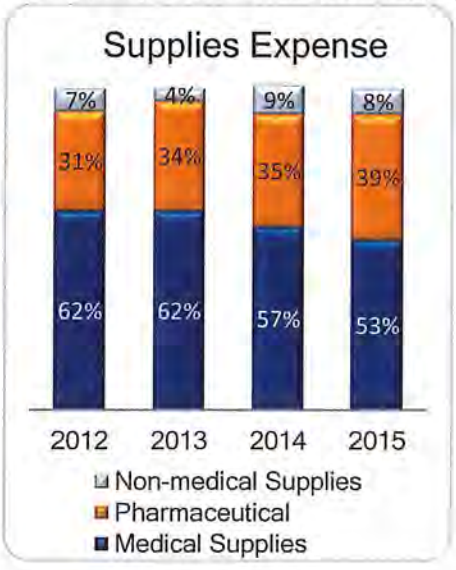
Key Efficiency Indicators *Data is year-to-date*	2015	2014	Organic Growth*
FTEs (presented in thousands)	70.4	65.4	67.1
Productivity - Labor % Net Service Rev.	50.8%	52.0%	50.9%
Supplies % Net Service Revenue	17.6%	17.7%	17.5%
Efficiency - Expense/CMAA	$ 12,040	$ 11,270	$ 12,070

** Reflects 2015 year-to-date results from entities that have been affiliated with Providence for more than 12 months.*

Year-to-date operating expenses were 15.6 percent higher than the prior year, which followed the 15.6 increase in operating revenue. Fees from provider tax related programs were $528 million in 2015 while no related expenses were recorded in 2014. Timing of program approval by regulating agencies resulted in all 2014 related expenses totaling $190 million being recorded in 2015. Expense growth was correlated with the higher patient volumes experienced in 2015. After removing the impact of provider fee taxes, growth of salary expenses and supply expenses outpaced operating expenses on a percentage basis, while benefits expenses and depreciation grew at a slower pace.

Year-to-date labor expense, defined as the combination of salaries and wages, employee benefits, and purchased services, was $1.0 billion or 13.4 percent higher than the prior year. Full-time equivalents (FTEs) of 70.4 thousand increased 7.6 percent, which represented an increase of 5.0 thousand FTEs. Labor expense growth outpaced FTEs in part due to high utilization of agency labor in 2015 to staff open positions. Agency labor increased 69 million or 42.3 percent in 2015 compared to the prior year. Higher salary expense was also a reflection of strategic investments made to move Providence to an institutes model of management. Total salary expense increased 14.0 percent while total benefits expense increased 11.3 percent compared to the prior year. Per member per month (PMPM) employee medical costs in 2015 were 3.8 percent higher over the prior year in part due to higher pharmaceutical costs.

Supply expenses increased $279 million or 15.6 percent compared to the prior year, but decreased slightly as a percentage of total net service revenue from 17.7 percent in 2014 to 17.6 percent in 2015. Medical supply expenses, a component of total supply expenses, increased 8.7 percent compared to the prior year which was in line with the growth in volume increases. Pharmaceutical expenses, the other significant component of supply expense, increased 30.4 percent compared to the prior year. Just under a third of the increase was volume driven with the remainder a result of price increases. Ten drugs accounted for 33 percent of the year-over-year price inflation from wholesaler drug purchases. Particularly high inflation was experienced among sole-source generic drugs and specialty pharmaceuticals. Market forces continue to move toward consolidation of generic drug producers, leading to significant price increases. In 2015 half of drugs purchased by Providence were branded drugs for which we have no ability to negotiate discounted rates. Continued consolidations of generic



drug producers is reducing the availability of options in the generics market by converting low cost generics to sole source branded suppliers.

Non-operating Income

Non-operating gains and losses are primarily comprised of investment income, pension settlement costs, and innovation projects expense. Pension settlement costs and innovation expenses were $34 million and $27 million through December, respectively. The remaining balance of non-operating income was driven by investment losses for the year, which were $114 million as compared to $178 million in positive investment income in 2014.

Investment Performance

Allocation by Asset Class *(Dollar figures presented in millions)*	Providence 12/31/15 Balance	Percent Allocation	Annual Return
Equities	$1,314	23%	$(54)
Fixed income	2,231	38%	2
Alternative Investments	861	15%	(66)
Cash & Other	1,396	24%	4
Total	**$5,802**	**100%**	**$(114)**

Within our portfolio, we saw growth hedge funds and our public and private debt positions outperform their respective indices for the year. Assets underperformed largely due to current allocations to Master Limited Partnerships (MLPs), Risk Parity and Commodities.

On a year-to-date basis, consolidated asset investments returned -3.22 percent, compared to the policy benchmark return of -2.54 percent. On a relative basis, our public equity pool returned -4.72 percent, driven by severe underperformance in Risk Parity, compared to the MSCI AC World IMI index return of -2.19 percent. Fixed income assets for the year returned 0.95 percent compared to the Barclays US Aggregate Index annual return of 0.55 percent; and our Alternative Investments returned 1.48 percent compared to our Alternative Investment Composite benchmark return of 1.03 percent.

Credit Agency Ratings

Providence received affirmation on the following ratings from the three national credit rating agencies during the latest round of reviews in June and July.

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

Ratings from all three agencies remained unchanged from the prior year, and all agencies issued a stable outlook based on improved year-over-year operating performance and stable balance sheet measures.

Debt Supported by Self-Liquidity

PH&S has authorized $200 million in taxable commercial paper that is supported by self-liquidity. As of December 31, 2015, $125 million in commercial paper was outstanding.

The System reports monthly on its cash and investment balances available to retire maturing short-term debt in the event notes cannot be remarketed. The table below summarizes the information provided to the rating agencies at the end of the fourth quarter describing cash and investments that could be available for liquidation.

Standard & Poor's Liquidity Assessment Coverage Calculation Spreadsheet (Last Revised January 2010)

INSTRUCTIONS: Fill in Green Cells to Compute Coverage Amounts

Liquidity Assessment Provider Name: Providence Health & Services
Portfolio As of Date: December 31, 2015

Asset Allocation (Security Type)	Assets ($ millions) with same day liquidity (T+0)	Assets ($ millions) with next day liquidity (T+1)	Assets ($ millions) with > same day liquidity (T+2, T+3,...T+n)	$ in Millions	Discount Factor	Discounted Assets
Cash & Cash Equivalents *	$ 524.03	$ -	$ -	$ 524.03	1.00	$ 524.03
S&P rated money market funds (> Am)	$ 206.41	$ -	$ -	$ 206.41	1.00	$ 206.41
Highly rated (A-1 or A-1+) dedicated bank line	$ -	$ -	$ -	$ -	1.00	$ -
Highly rated (A-1 or A-1+) money market instruments (< 1yr)	$ -	$ 4.01	$ -	$ 4.01	0.91	$ 3.64
U.S. Treasury Debt Obligations (> 1 year)	$ -	$ 304.34	$ -	$ 304.34	0.91	$ 276.67
U.S. TIPs	$ -	$ 94.25	$ -	$ 94.25	0.87	$ 81.95
U.S. Agencies (> 1 year)	$ -	$ 95.97	$ -	$ 95.97	0.83	$ 79.97
Investment Grade Debt (that is not included above)	$ -	$ -	$ 229.16	$ 229.16	0.67	$ 152.78
Equities**	$ -	$ -	$ 393.41	$ 393.41	0.50	$ 196.71
Non-Investment Grade Debt	$ -	$ -	$ 6.87	$ 6.87	0.40	$ 2.75
Total	$ 730.44	$ 498.56	$ 629.45	$ 1,858.44		$ 1,524.91
Discounted Total	$ 730.44	$ 442.24	$ 352.23			Discounted Total

	Enter amount of Self Liquidity Backed Debt with:		
	Same Day Notice	Next Day Notice	> Next Day Notice
Commercial Paper		$ 100.00	$ 100.00
Variable Rate Demand Note or Obligation	$ -		$ -
Fixed Rate Debt			
Other Securities			
Total	$ -	$ 100.00	$ 100.00
Remaining Discounted Assets	$ 730.44	$ 1,072.68	$ 1,324.91
	Same Day +/-	Next Day +/-	> Next Day +/-
	Sufficient	Sufficient	Sufficient

TOTAL DEBT SUPPORTED BY SELF LIQUIDITY	TOTAL REMAINING DISCOUNTED ASSETS
$ 200.00	$ 1,324.91

Performance Metrics	December 31, 2015		
	Year-To-Date Actual	Year-To-Date Budget	Year-To-Date Last Year
Volume:			
Acute Adjusted Admissions	651,198	630,518	602,468
Total Acute Admissions	361,689	352,410	333,263
Total Acute Patient Days	1,630,317	1,561,749	1,495,451
Acute Outpatient Visits	8,484,580	8,297,727	8,005,170
Observations	56,353	58,908	57,965
Primary Care Visits	7,741,961	7,789,622	6,881,113
Long-Term Care Patient Days	410,672	420,836	411,517
Home Health Visits	697,040	679,430	667,708
Hospice Days	642,506	663,325	628,182
Housing and Assisted Living Days	568,913	525,451	564,110
Health Plan Members	513,113	461,681	436,930
Total Occupancy %	64.8%	62.4%	59.5%
Total Average Daily Census	4,467	4,279	4,097
Surgeries:			
Inpatient	115,639	112,853	106,414
Outpatient	128,263	119,803	120,890
Total Surgeries	243,902	232,656	227,304
Emergency Room Visits:			
Inpatient	195,313	189,860	179,129
Outpatient	1,261,493	1,176,269	1,152,536
Total Emergency visits	1,456,806	1,366,129	1,331,665
Outpatient Visits:			
Outpatient Surgery	128,263	119,803	120,890
Emergency Visits	1,261,493	1,176,269	1,152,536
Primary Care	7,741,961	7,789,622	6,881,113
Homecare Visits	697,040	679,430	667,708
Observations	56,353	58,908	57,965
All Other	7,038,471	6,942,748	6,673,778
Total Outpatient Visits	16,923,581	16,766,780	15,553,990

Performance Metrics	December 31, 2015		
	Year-To-Date Actual	Year-To-Date Budget	Year-To-Date Last Year
Efficiency:			
FTE's	70,438	69,328	65,369
YTD Overall Case-Mix Index	1.5738	1.5635	1.5699
YTD Case-Mix Adj Admissions (CMAA)	1,024,874	985,840	945,794
YTD Acute Care LOS (case-mix adj)	2.9	2.8	2.9
YTD Net Svc Rev/CMAA	12,295	11,931	11,499
YTD Net Expense/CMAA	12,040	11,727	11,270
YTD Paid Hours/CMAA	143	146	140
YTD Productive Hours/CMAA	127	130	124
FTE's Per Adjusted Occupied Bed	8.76	9.06	8.62
Financial Performance:			
Operating Margin	1.8%	1.5%	1.8%
Total Margin	0.5%	3.5%	5.9%
EBIDA ('000)	864,158	1,341,871	1,132,694
EBIDA Margin	6.0%	9.9%	5.7%
R12 Days of Total Cash on Hand	159	156	183
Net Patient AR Days (3 mo rolling ave)	47	63	50
Ave Yearly Salary/FTE (w/o benefits)	84,950	83,353	82,171
Employee Benefits as a % of Salaries	22.7%	23.9%	23.2%
Salary Wages as a % of Net Op Rev	41.5%	42.5%	42.0%
Supplies as a % of Net Op Revenue	14.4%	13.7%	14.4%
YTD Supplies Expense/CMAA	2,022	1,886	1,895
YTD Med Supplies Exp/CMAA	1,077	1,045	1,073
Debt to Total Net Asset Ratio	33.8	30.6	33.8
Cash to Debt Ratio	138.1	131.4	130.9
Current Ratio	1.4	1.8	1.5
Bad Debt & Charity % Gross Svc Rev	2.2%	3.0%	2.8%
Community Benefit: ('000)			
Cost of Charity Care Provided	$ 180,256	$ 215,219	$ 205,555
Medicaid Charity	537,894	460,180	443,622
Education and Research Programs	112,826	79,288	96,988
Unpaid Cost of Other Govt Programs	47	1,088	1,157
Negative Margin Services and Other	68,095	61,507	57,355
Non-Billed Services	52,206	26,025	43,806
Total Community Benefit	$ 951,324	$ 843,307	$ 848,483

PROVIDENCE HEALTH & SERVICES

Combined Financial Statements

December 31, 2015 and 2014

(With Independent Auditors' Report Thereon)

KPMG LLP
Suite 2900
1918 Eighth Avenue
Seattle, WA 98101

Independent Auditors' Report

The Board of Directors
Providence Health & Services:

We have audited the accompanying combined financial statements of Providence Health & Services, which comprise the combined balance sheets as of December 31, 2015 and 2014, and the related combined statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the combined financial statements.

Management's Responsibility for the Combined Financial Statements

Management is responsible for the preparation and fair presentation of these combined financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of combined financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these combined financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the combined financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the combined financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the combined financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the combined financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the combined financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the combined financial statements referred to above present fairly in all material respects, the financial position of Providence Health & Services as of December 31, 2015 and 2014, and the results of their operations and their cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

Other Matter

Our audits were conducted for the purpose of forming an opinion on the combined financial statements as a whole. The supplemental information, included on pages 38 and 39 is presented for the purpose of additional analysis and is not a required part of the combined financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the combined financial statements. The information has been subjected to the auditing procedures applied in the audit of the combined financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the combined financial statements or to the combined financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the combined financial statements as a whole.

KPMG LLP

Seattle, Washington
March 9, 2016

PROVIDENCE HEALTH & SERVICES

Combined Balance Sheets

December 31, 2015 and 2014

(In thousands of dollars)

Assets		2015	2014
Current assets:			
Cash and cash equivalents	$	729,321	1,237,337
Short-term management-designated investments		200,251	199,338
Accounts receivable, less allowance for bad debts of $343,835 in 2015 and $289,908 in 2014		1,569,827	1,419,495
Other receivables, net		399,291	375,185
Supplies inventory		194,619	185,821
Other current assets		140,836	203,337
Current portion of funds held by trustee		54,740	76,365
Total current assets		3,288,885	3,696,878
Assets whose use is limited:			
Management-designated cash and investments		4,930,858	4,601,153
Gift annuities, trusts, and other		93,804	53,954
Funds held by trustee		272,902	179,473
Assets whose use is limited, net of current portion		5,297,564	4,834,580
Property, plant, and equipment, net		6,580,860	6,622,566
Other assets		572,968	568,884
Total assets	$	15,740,277	15,722,908

See accompanying notes to combined financial statements.

(Continued)

PROVIDENCE HEALTH & SERVICES

Combined Balance Sheets

December 31, 2015 and 2014

(In thousands of dollars)

Liabilities and Net Assets		2015	2014
Current liabilities:			
Current portion of long-term debt	$	244,532	202,287
Master trust debt classified as short-term		137,500	12,500
Accounts payable		427,567	521,942
Accrued compensation		641,406	738,075
Payable to contractual agencies		104,651	151,778
Retirement plan obligations		190,278	185,517
Current portion of self-insurance liability		118,898	108,943
Other current liabilities		463,198	465,865
Total current liabilities		2,328,030	2,386,907
Long-term debt, net of current portion		3,729,795	3,844,262
Other long-term liabilities:			
Self-insurance liability, net of current portion		292,843	274,541
Pension benefit obligation		1,063,581	1,040,939
Other liabilities		290,380	227,099
Total other long-term liabilities		1,646,804	1,542,579
Total liabilities		7,704,629	7,773,748
Net assets:			
Unrestricted:			
Controlling interest		7,541,875	7,492,324
Noncontrolling interest		44,904	45,302
Temporarily restricted		324,891	305,277
Permanently restricted		123,978	106,257
Total net assets		8,035,648	7,949,160
Total liabilities and net assets	$	15,740,277	15,722,908

See accompanying notes to combined financial statements.

PROVIDENCE HEALTH & SERVICES

Combined Statements of Operations

Years ended December 31, 2015 and 2014

(In thousands of dollars)

	2015	2014
Operating revenues:		
Net patient service revenues	$ 11,969,116	10,294,637
Provision for bad debts	(185,567)	(193,018)
Net patient service revenues less provision for bad debts	11,783,549	10,101,619
Premium and capitation revenues	1,862,236	1,682,968
Other revenues	787,996	696,390
Total operating revenues	14,433,781	12,480,977
Operating expenses:		
Salaries and wages	5,983,719	5,248,196
Employee benefits	1,357,703	1,220,078
Purchased healthcare	1,045,019	909,154
Professional fees	582,600	514,990
Supplies	2,072,005	1,792,707
Purchased services	1,105,189	977,247
Depreciation	630,537	676,357
Interest	153,480	155,343
Amortization	720	5,671
Other	1,240,993	762,082
Total operating expenses	14,171,965	12,261,825
Excess of revenues over expenses from operations	261,816	219,152
Net nonoperating (losses) gains:		
Gain from affiliations	—	476,110
Loss on extinguishment of debt	(69)	(85,522)
Investment (losses) income, net	(113,617)	178,043
Pension settlement costs and other	(71,305)	(16,361)
Total net nonoperating (losses) gains	(184,991)	552,270
Excess of revenues over expenses	76,825	771,422
Net assets released from restriction for capital	20,372	13,646
Change in noncontrolling interests in consolidated joint ventures	(398)	584
Pension related changes	(27,415)	(249,011)
Contributions, grants, and other	(20,231)	(8,639)
Increase in unrestricted net assets	$ 49,153	528,002

See accompanying notes to combined financial statements.

PROVIDENCE HEALTH & SERVICES

Combined Statements of Changes in Net Assets

Years ended December 31, 2015 and 2014

(In thousands of dollars)

	Unrestricted: controlling interest	Unrestricted: noncontrolling interest	Temporarily restricted	Permanently restricted	Total net assets
Balance, December 31, 2013	$ 6,964,906	44,718	223,548	84,313	7,317,485
Excess of revenues over expenses	771,422	—	—	—	771,422
Restricted contributions from affiliations	—	—	50,401	14,515	64,916
Contributions, grants, and other	(8,639)	—	93,563	7,429	92,353
Net assets released from restriction	13,646	—	(62,235)	—	(48,589)
Change in noncontrolling interests in consolidated joint ventures	—	584	—	—	584
Pension related changes	(249,011)	—	—	—	(249,011)
Increase in net assets	527,418	584	81,729	21,944	631,675
Balance, December 31, 2014	7,492,324	45,302	305,277	106,257	7,949,160
Excess of revenues over expenses	76,825	—	—	—	76,825
Contributions, grants, and other	(20,231)	—	88,214	17,721	85,704
Net assets released from restriction	20,372	—	(68,600)	—	(48,228)
Change in noncontrolling interests in consolidated joint ventures	—	(398)	—	—	(398)
Pension related changes	(27,415)	—	—	—	(27,415)
Increase in net assets	49,551	(398)	19,614	17,721	86,488
Balance, December 31, 2015	$ 7,541,875	44,904	324,891	123,978	8,035,648

See accompanying notes to combined financial statements.

PROVIDENCE HEALTH & SERVICES

Combined Statements of Cash Flows

Years ended December 31, 2015 and 2014

(In thousands of dollars)

		2015	2014
Cash flows from operating activities:			
Increase in net assets	$	86,488	631,675
Adjustments to reconcile increase in net assets to net cash provided by operating activities:			
Gains from affiliations		—	(541,026)
Depreciation and amortization		631,257	682,028
Provision for bad debt		185,567	193,018
Loss on extinguishment of debt		69	85,522
Equity income from joint ventures		(40,871)	(39,159)
Restricted contributions and investment income received		(112,763)	(94,024)
Net realized and unrealized losses (gains) on investments		187,912	(109,622)
Distributions from joint ventures		47,424	37,687
Changes in certain current assets and current liabilities		(492,347)	(21,062)
Change in certain long-term assets and liabilities		104,225	266,280
Net cash provided by operating activities		596,961	1,091,317
Cash flows from investing activities:			
Property, plant, and equipment additions		(637,262)	(537,301)
Proceeds from disposal of property, plant, and equipment		8,354	6,901
Purchases of investments		(6,851,705)	(5,555,329)
Proceeds from sales of investments		6,293,325	5,340,773
Change in other long-term assets and other		(12,463)	11,199
Change in funds held by trustee, net		(71,804)	(35,630)
Cash paid for affiliations, net of cash acquired		—	(98,958)
Net cash used in investing activities		(1,271,555)	(868,345)
Cash flows from financing activities:			
Proceeds from restricted contributions and restricted income		112,763	94,024
Debt borrowings		453,088	1,193,228
Debt payments		(400,379)	(1,112,836)
Other financing activities		1,106	(13,016)
Net cash provided by financing activities		166,578	161,400
(Decrease) increase in cash and cash equivalents		(508,016)	384,372
Cash and cash equivalents, beginning of year		1,237,337	852,965
Cash and cash equivalents, end of year	$	729,321	1,237,337
Supplemental disclosure of cash flow information:			
Cash paid for interest (net of amounts capitalized)	$	141,554	136,066

See accompanying notes to combined financial statements.

(1) Organization

(a) Sisters of Providence

Sisters of Providence (the Congregation), a religious congregation of Roman Catholic women, was founded in 1843. The religious congregation's central headquarters is in Montreal, Quebec, Canada. Sisters of Providence – Mother Joseph Province (the Province) was formed in 2000 through the combination of the Sacred Heart Province (founded in 1856) and the St. Ignatius Province (founded in 1891). The activities of the Province include apostolic works in healthcare, social services, and education. Members of the Province serve in these works through related and unrelated organizations. The Province is compensated for the services of its members. The Province has 130 professed members and maintains provincial administration offices in Renton, Washington. The members of the Province represent the Congregation in the following:

- Archdiocese of Los Angeles, California
- Archdiocese of Portland, Oregon
- Archdiocese of Seattle, Washington
- Diocese of Cubao, Philippines
- Diocese of Orlando, Florida
- Diocese of Spokane, Washington
- Diocese of Yakima, Washington
- Diocesis Santiago de Maria, El Salvador

(b) Providence Health & Services

The Public Juridic Person, Providence Ministries, is the sole Member of Providence Health & Services and controls certain aspects of the various corporations comprising Providence Health & Services through certain reserved rights.

Providence Ministries sponsors various corporations comprising Providence Health & Services including:

- Providence Health & Services – Washington
- Providence Health & Services – Oregon
- Providence Health System – Southern California (cosponsored by the Congregation and the American Province of the Little Company of Mary Sisters)
- Providence Health & Services – Montana
- Providence St. Joseph Medical Center
- St. Thomas Child and Family Center Corporation
- University of Great Falls

- Providence Plan Partners
- Providence Health Plan (the Health Plan)
- Providence Health Assurance
- Providence Health System Housing; The St. Luke Association; The Lundberg Association; Providence St. Francis Association; Providence Blanchet Association; Providence Rossi Association; Providence Peter Claver Association; The Gamelin Association; The Gamelin Oregon Association; The Gamelin California Association; Providence St. Elizabeth House Association; Gamelin Washington Association; Providence Gamelin House Association
- Providence Oregon Management Corporation
- Providence Ventures, Inc.
- Providence Assurance, Inc.
- Inland Northwest Health Services

Providence Ministries and Western HealthConnect are co-Members of Providence Health & Services – Western Washington.

Western HealthConnect, a secular Washington nonprofit corporation, is the sole corporate member of the following organizations:

- Swedish Health Services
- Swedish Edmonds
- Kadlec Regional Medical Center
- PacMed Clinics D/B/A Pacific Medical Centers
- Western HealthConnect Ventures, Inc.
- Health Connect Partners

Providence Health & Services and Western HealthConnect, inclusive of all sponsored and corporate members, are collectively referred to as the Health System.

The Health System owns or operates 34 general acute care hospitals, three ambulatory care centers, six medical groups, six long-term care facilities, seven homecare and hospice entities, five assisted living facilities, a high school, a university, 13 low-income housing projects, the Health Plan, a health services contractor, two programs of all inclusive care for the elderly, and 23 controlled fundraising foundations.

The Health System provides inpatient, outpatient, primary care, and home care services in Alaska, Washington, Montana, Oregon, and Southern California. The Health System operates these businesses primarily in the greater metropolitan areas of Anchorage, Alaska; Seattle, Spokane, Kennewick, and Olympia, Washington; Missoula, Montana; Portland and Medford, Oregon; and Los Angeles, California.

(Continued)

(c) Tax Exempt Status

The Health System and substantially all of the various corporations within the Health System have been recognized as exempt from federal income taxes, except on unrelated business income, under Section 501(a) of the Internal Revenue Code (IRC) as an organization described in Section 501(c)(3) of the IRC.

Providence Plan Partners, Providence Health Plan, and Providence Health Assurance are not-for-profit entities and have been recognized as exempt from federal income taxes, except on unrelated business income, as social welfare organizations under Section 501(c)(4) of the IRC.

(d) Organizational Changes

Affiliation Activity

Effective March 1, 2014, the Health System entered into an affiliation agreement with Sisters of Charity of Leavenworth Health System (SCL) to transfer sponsorship of Saint John's Health Center (Saint John's) to the Health System. Saint John's operates a nonprofit medical center, a cancer institute, and physician clinics to serve the Santa Monica, California community and surrounding area. The fair value of the net assets acquired was $430,728,000, which included $64,487,000 in restricted net assets. Unrestricted net assets of $366,241,000 exceeded total cash consideration of $186,217,000. The Health System recognized a gain from affiliation in the amount of $180,024,000 as the excess of the fair value of the unrestricted net assets over total consideration. The $64,487,000 of restricted net assets is recorded in restricted net assets in the combined statement of changes in net assets. The results of operations of Saint John's entities have been included in the combined statements of operations of the Health System effective as of the date of affiliation during 2014.

Effective May 1, 2014, the Health System entered into an affiliation agreement with PacMed Clinics (PacMed). PacMed is a private, nonprofit, multi-specialty medical group with nine clinics in the Puget Sound area and more than 150 primary care and specialty providers at the date of affiliation. Pursuant to the affiliation agreement, Western HealthConnect became PacMed's sole corporate Member. No cash or other purchase consideration was transferred to effect the affiliation. The results of operations of PacMed entities have been included in the combined statements of operations of the Health System effective as of the date of affiliation. The affiliation resulted in an excess of assets acquired over liabilities assumed, or a contribution from PacMed to the Health System of $84,717,000, which is included in gain from affiliation during 2014.

Effective June 13, 2014, the Health System entered into an affiliation agreement with Kadlec Health System (Kadlec). Kadlec operates a nonprofit medical center, a neurological resource center, a supporting foundation, and physician clinics to serve the area of Kennewick, Pasco, and Richland, Washington. Pursuant to the affiliation agreement, Western HealthConnect became the sole member of Kadlec. No cash or other purchase consideration was transferred to effect the affiliation. The results of operations of Kadlec have been included in the combined statements of operations of the Health System effective as of the date of affiliation. The affiliation resulted in an excess of assets acquired over liabilities assumed, or a contribution from Kadlec to the Health System of $211,798,000. The unrestricted portion of the contribution of $211,369,000 is included in gain from affiliation in the

accompanying combined statement of operations. The remaining $429,000 of the contribution is recorded in restricted net assets in the combined statement of changes in net assets during 2014.

The financial results of the affiliated entities discussed above are included in the Health System's 2014 combined statement of operations from the effective date of each respective affiliation through December 31, 2014. The following table summarizes the aggregate amounts included in the 2014 combined statement of operations (in thousands of dollars) related to the affiliated entities, excluding gain from affiliations:

Total operating revenues	$	648,634
Excess of revenues over expenses from operations		52,151
Excess of revenues over expenses		39,369

The following table summarizes the aggregate amounts included in the December 31, 2014 combined balance sheets related to the affiliated entities discussed above (in thousands of dollars):

Cash and investments	$	201,534
Accounts receivable, net of allowances		103,444
Property, plant, and equipment, net		594,323
Other assets		189,408
Total assets	$	1,088,709
Accounts payable and accrued compensation	$	93,604
Long-term debt, net of current portion		343,614
Other liabilities		97,571
Total liabilities		534,789
Net assets		553,920
Total liabilities and net assets	$	1,088,709

(2) Summary of Significant Accounting Policies

(a) Basis of Presentation

The financial statements of the Health System are presented on a combined basis due to the operational interdependence of the organization and because the respective Boards of Directors and corporate officers of Providence Health & Services and Western HealthConnect are comprised of the same individuals. All significant transactions and accounts between divisions and combined affiliates of the Health System have been eliminated. The Health System has performed an evaluation of subsequent events through March 9, 2016, which is the date these combined financial statements were issued.

(b) Use of Estimates

The preparation of the combined financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the combined financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

(c) Cash and Cash Equivalents

Cash and cash equivalents include investments in highly liquid debt instruments with an original or remaining maturity of three months or less when acquired.

(d) Supplies Inventory

Supplies inventory is stated at the lower of cost (first-in, first-out) or market.

(e) Property, Plant, and Equipment

Property, plant, and equipment are stated at cost. Improvements and replacements of plant and equipment are capitalized. Maintenance and repairs are expensed. The cost of the property, plant, and equipment sold or retired and the related accumulated depreciation are removed from the accounts, and the resulting gain or loss is recognized at the time of disposal.

The Health System assesses potential impairment to their long-lived assets when there is evidence that events or changes in circumstances have made recovery of the carrying value of the assets unlikely. An impairment loss, equal to the excess, if any, of the carrying value over the fair value less disposal costs, is recognized when the sum of the expected future undiscounted net cash flows from the use and disposal of the asset is less than the carrying amount of the asset.

(f) Depreciation

The provision for depreciation is determined by the straight-line method, which allocates the cost of tangible property equally over its estimated useful life or lease term.

(g) Capitalized Interest

Interest capitalized on amounts expended during construction is a component of the cost of additions to be allocated to future periods through the provision for depreciation. Capitalization of interest ceases when the addition is substantially complete and ready for its intended use. The Health System capitalized $10,573,000 and $4,044,000 of interest costs during the years ended December 31, 2015 and 2014, respectively.

(h) Financing Costs

Financing costs are recorded in other assets and are amortized using the effective-interest method over the term of the related debt, or to the earliest date at which a creditor can demand payment.

(i) Goodwill and Indefinite Lived Intangible Assets

Goodwill and indefinite lived intangible assets, which are not amortized as they are considered to have an indefinite life, are recorded in other assets as the excess of cost over fair value of the acquired net assets. Goodwill and indefinite lived intangible assets are tested at least annually for impairment.

(j) Intangible Assets with a Finite Life

Intangible assets that are determined to have a finite life are recorded in other assets. Such assets are amortized by the straight-line method, which allocates the cost of tangible property equally over the asset's estimated useful life or agreement term.

(k) Assets Whose Use Is Limited

The Health System has designated all of its investments in debt and equity securities, hedge funds, and collective investment funds as trading. These investments are reported on the combined balance sheets at fair value.

Assets whose use is limited primarily include assets held by trustees under indenture agreements, self-insurance funds, funds held for the payment of health plan medical claims and other statutory reserve requirements, assets held by related foundations, and designated assets set aside by the management of Providence Health & Services for future capital improvements and other purposes, over which management retains control.

Assets held by trustee obtained from borrowings under the Health System's master trust indenture for construction and other ongoing projects were $133,594,000 and $51,433,000 as of December 31, 2015 and 2014, respectively. Assets held by trustee for purposes of funding future obligations related to certain self-insurance programs and retirement plans were $171,075,000 and $190,819,000 at December 31, 2015 and 2014, respectively.

(l) Net Assets

Unrestricted net assets are those that are not subject to donor-imposed stipulations. Amounts related to the Health System's noncontrolling interests in certain joint ventures are included in unrestricted net assets. Temporarily restricted net assets are those whose use by the Health System has been limited by donors to a specific time period and/or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Health System in perpetuity. Unless specifically stated by donors, gains and losses on temporarily and permanently restricted net assets are recorded as temporarily restricted.

(m) Donor-Restricted Gifts

Unconditional promises to give cash and other assets to the Health System are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received. The gifts are reported as either temporarily or permanently restricted contributions if they are received with donor stipulations that limit the use of the donated assets. When the terms of a donor restriction are met, temporarily restricted net assets are reclassified as unrestricted net assets and reported as other operating revenues in the combined statements of operations or changes in net assets as net assets released from restriction.

(Continued)

(n) Net Patient Service Revenues

The divisions of the Health System have agreements with governmental and other third-party payors that provide for payments to the divisions at amounts different from the Health System's established charges. Payment arrangements for major third-party payors may be based on prospectively determined rates, reimbursed cost, discounted charges, per diem payments, predetermined rates per HMO enrollee per month, or other methods.

Net patient service revenues are reported at the estimated net realizable amounts due from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with governmental payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as appropriate. Adjustments from finalization of prior years' cost reports and other third-party settlement estimates resulted in an increase in net patient service revenues of $44,786,000 and $31,098,000 for the years ended December 31, 2015 and 2014, respectively.

The composition of significant third-party payors for the years ended December 31, 2015 and 2014, as a percentage of net patient service revenues, is as follows:

	2015	2014
Commercial	50%	52%
Medicare	32	33
Medicaid	17	14
Self-pay	1	1
	100%	100%

(o) Provision for Bad Debts

The Health System provides for an allowance against patient accounts receivable for amounts that could become uncollectible. The Health System estimates this allowance based on the aging of accounts receivable, historical collection experience by payor, and other relevant factors. There are various factors that can impact the collection trends, such as changes in the economy, which in turn have an impact on unemployment rates and the number of uninsured and underinsured patients, the increased burden of copayments to be made by patients with insurance coverage and business practices related to collection efforts. These factors continuously change and can have an impact on collection trends and the estimation process used by the Health System. The Health System records a provision for bad debts in the period of services on the basis of past experience, which has historically indicated that many patients are unresponsive or are otherwise unwilling to pay the portion of their bill for which

they are financially responsible. The estimates made and changes affecting those estimates for the years ended December 31, 2015 and 2014 are summarized below:

		2015	2014
		(In thousands of dollars)	
Changes in allowance for doubtful accounts:			
Allowance for doubtful accounts at beginning of year	$	289,908	358,966
Write-off of uncollectible accounts, net of recoveries		(131,640)	(262,076)
Provision for bad debts		185,567	193,018
Allowance for doubtful accounts at end of year	$	343,835	289,908

(p) Premium Revenues, Premiums Receivable, Unearned Premiums, and Capitation Revenues

Health plan revenues consist of premiums paid by employers, individuals, and agencies of the federal and state governments for healthcare services. Health plan revenues are received on a prepaid basis and are recognized as revenue during the month for which the enrolled member is entitled to healthcare services. Premiums received for future months are recorded as unearned premiums.

Similar to health plan premiums, capitation revenues are received on a prepaid basis and are recognized as revenue during the month for which the enrolled member is entitled to healthcare services.

(q) Other Operating Revenues

Other operating revenues include meaningful use revenue, rental revenue, equity earnings from joint ventures, contributions released from restrictions, cafeteria revenue, and other miscellaneous revenue.

(r) Charity and Unsponsored Community Benefit Costs

The divisions of the Health System have policies that provide for serving those without the ability to pay. The policies also provide for discounted sliding scale payments based on the income and assets of the person responsible for the bill. In addition to uncompensated care, the Health System's divisions also provide services that benefit the poor and others in the communities they serve.

Information for the Health System for the years ended December 31, 2015 and 2014 is summarized below:

		2015	2014
		(In thousands of dollars)	
Cost of charity care provided	$	180,256	205,555
Unpaid cost of Medicaid services		537,894	443,623
Unsponsored community benefit costs	$	718,150	649,178

The cost of charity care provided is calculated based on each division's aggregate relationship of costs to charges. The unpaid cost of Medicaid services is the cost of treating Medicaid patients in excess of government payments. Unpaid cost of Medicaid services are net of revenues of $1,552,853,000 and $1,377,866,000 for the years ended December 31, 2015 and 2014, respectively.

(Continued)

(s) Net Nonoperating Losses and Gains

Net nonoperating gains primarily include investment income from trading securities, income from recipient organizations, pension settlement costs, and other income. Additionally, contributions from affiliations with Saint John's, PacMed, and Kadlec are included in net nonoperating gains in 2014.

(t) Excess of Revenues over Expenses

Excess of revenues over expenses includes all changes in unrestricted net assets, except for net assets released from restriction for the purchase of property, certain changes in funded status of postretirement benefit plans, net changes in noncontrolling interests in combined joint ventures, and other.

(u) Income and Other Taxes

The Health System recognizes the effect of income tax positions only if those positions are more likely than not of being sustained upon an audit by the taxing authority. Recognized income tax positions are measured at the largest amount that is greater than 50% likely of being realized. Changes in recognition or measurement are reflected in the period in which the change in judgment occurs.

Various states in which the Health System operates have instituted a provider tax on certain patient service revenues at qualifying hospitals to increase funding from other sources and obtain additional Federal funds to support increased payments to providers for Medicaid services. These taxes are included in other expenses in the accompanying combined statements of operations and were $527,789,000 and $129,384,000 for the years ended December 31, 2015 and 2014, respectively. These programs resulted in enhanced payments from these states in the way of lump-sum payments and per claim increases. These enhanced payments are included in net patient service revenues in the accompanying combined statements of operations and were $612,282,000 and $129,349,000 for the years ended December 31, 2015 and 2014, respectively.

(v) Recently Issued or Adopted Accounting Standards

In May 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update No. (ASU) 2014-09, *Revenue from Contracts with Customers (Topic 606)*, to clarify the principles for recognizing revenue and to improve financial reporting by creating common revenue recognition guidance for GAAP and International Financial Reporting Standards. The core principle of the new guidance is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The amendments in the ASU can be applied either retrospectively to each prior reporting period presented or retrospectively with the cumulative effect of initially applying the update recognized at the date of the initial application along with additional disclosures. The Health System is currently evaluating the impact of ASU 2014-09, including the methods of implementation, which is effective for the fiscal year beginning on January 1, 2018.

In March 2015, the FASB issued ASU 2015-03, *Simplifying the Presentation of Debt Issuance Costs*. This update changes the presentation of debt issuance costs in the financial statements. Under the ASU, an entity presents such costs in the balance sheet as a direct deduction from the recognized liability rather than as an asset. Amortization of the costs is reported as interest expense. The Health System

has considered the provisions of this standard and will adopt in the fiscal year beginning January 1, 2016. The Health System does not believe that the provisions of this standard will have a material impact in its combined financial statements.

In May 2015, the FASB issued ASU 2015-07, *Fair Value Measurement (Topic 820) – Disclosures for Investments in Certain Entities That Calculate Net Asset Value per Share (or Its Equivalent)*, which eliminates the requirement to categorize investments in the fair value hierarchy if their fair value is measured at net asset value per share, or its equivalent, (NAV) using the practical expedient in the FASB's fair value measurement guidance. The Health System adopted this standard effective December 31, 2015. As a result of the adoption of the standard, the Health System modified its fair value hierarchy disclosures.

In February 2016, the FASB issued ASU 2016-02, *Leases (Topic 842)*, which requires lessees to recognize a lease liability and a right of use asset for all lease obligations with exception to short-term leases. The lease liability will represent the lessee's obligation to make lease payments arising from the lease measured on a discounted basis and the right of use asset will represent the lessee's right to use or control the use of a specified asset for a lease term. The lease guidance also simplifies accounting for sale leaseback transactions. The Health System is currently evaluating the impact of ASU 2016-02, which is effective for the fiscal year beginning on January 1, 2019 with retrospective application to the earliest presented period.

(w) Reclassifications

Certain reclassifications have been made to prior year amounts to conform to the current year presentation.

(3) Fair Value of Financial Instruments

ASC Topic 820 (Topic 820), *Fair Value Measurements*, establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 inputs are quoted prices (unadjusted) in active markets for identical assets or liabilities that the Health System has the ability to access at the measurement date.
- Level 2 inputs are inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly.
- Level 3 inputs are unobservable inputs for the asset or liability.

The level in the fair value hierarchy within which a fair value measurement in its entirety falls is based on the lowest level input that is significant to the fair value measurement in its entirety.

The fair value of assets whose use is limited, other than those investments measured using NAV as a practical expedient for fair value, is estimated using quoted market prices or other observable inputs when quoted market prices are unavailable. For long-term debt, the fair value is based on Level 2 inputs, such as the

discounted value of the future cash flows using current rates for debt with the same remaining maturities, considering the existing call premium and protection. The carrying value and fair value of long-term debt, including accrued interest, was $4,149,702,000 and $4,438,718,000, respectively, as of December 31, 2015, and $4,097,789,000 and $4,421,616,000, respectively, as of December 31, 2014.

Other financial instruments of the Health System include cash and cash equivalents and other current assets and liabilities. The carrying amount of these instruments approximates fair value because these items mature in less than one year.

The following table presents the Health System's activity for assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) as defined in Topic 820 for the years ended December 31, 2015 and 2014 (in thousands of dollars):

Balance at December 31, 2013	$	25,950
Total realized and unrealized gains (losses), net		(2,257)
Total purchases		1,418
Total sales		(1,072)
Transfers into Level 3		2,997
Balance at December 31, 2014	$	27,036
Total realized and unrealized gains (losses), net		(131)
Total purchases		30,398
Total sales		(2,258)
Transfers into Level 3		10,982
Transfers out of Level 3		(3,895)
Balance at December 31, 2015	$	62,132

There were no significant transfers between assets classified as Level 1 and Level 2 during the years ended December 31, 2015 and 2014.

Level 3 assets include charitable remainder trusts, real property and equity investments in healthcare technology start-ups through the Health System's innovation venture capital fund. Fair values of real property were estimated using a market approach. Fair values of charitable remainder trusts were estimated using an income approach. Fair value of equity investments in healthcare technology start-ups were estimated using a combination of income and market approach.

(Continued)

(4) Assets Whose Use is Limited

The composition of assets whose use is limited at December 31, 2015 is set forth in the following table:

	December 31, 2015	Fair value measurements at reporting date using		
		Level 1	Level 2	Level 3
		(In thousands of dollars)		
Management-designated cash and investments:				
Cash and cash equivalents	$ 613,736	613,736	—	—
Domestic equity securities:				
Mutual funds:				
Large capitalization	183,018	183,018	—	—
Medium-small cap and other	149,291	149,291	—	—
Technology	133,510	133,510	—	—
Financial services	103,049	103,049	—	—
Consumer services	93,663	93,663	—	—
Other industries	196,044	196,044	—	—
Foreign equity securities:				
Mutual funds:				
Large capitalization	91,639	91,639	—	—
Medium-small cap and other	64,545	64,545	—	—
Other industries	68,034	68,034	—	—
Debt securities – U.S. Treasury	1,001,525	717,466	284,059	—
Debt securities – State Treasury	27,754	—	27,754	—
Domestic corporate debt securities	643,590	—	643,590	—
Foreign corporate debt securities	87,423	—	87,423	—
Other	272,782	515	272,267	—
Investments measured using NAV	1,401,506			
Total management-designated cash and investments	$ 5,131,109			
Gift annuities, trusts, and other	$ 93,804	23,856	7,816	62,132
Funds held by trustee:				
Cash and cash equivalents	$ 176,134	176,134	—	—
Domestic equity securities	334	334	—	—
Foreign equity securities	162	162	—	—
Debt securities – U.S. Treasury	64,874	63,650	1,224	—
Domestic corporate debt securities	48,478	—	48,478	—
Foreign corporate debt securities	15,971	—	15,971	—
Collateralized debt securities	21,108	—	21,108	—
Other	581	87	494	—
Total funds held by trustee	$ 327,642			

(Continued)

The composition of assets whose use is limited at December 31, 2014 is set forth in the following table:

	December 31, 2014	Fair value measurements at reporting date using		
		Level 1	Level 2	Level 3
		(In thousands of dollars)		
Management-designated cash and investments:				
Cash and cash equivalents	$ 401,728	401,728	—	—
Domestic equity securities:				
Mutual funds:				
Large capitalization	139,544	139,544	—	—
Medium-small cap and other	143,501	143,501	—	—
Consumer services	269,565	269,565	—	—
Financial services	129,676	129,676	—	—
Technology	105,950	105,950	—	—
Other industries	120,761	120,761	—	—
Foreign equity securities:				
Mutual funds				
Large capitalization	177,185	177,185	—	—
Medium-small cap and other	39,315	39,315	—	—
Other industries	83,455	83,455	—	—
Debt securities – U.S. Treasury	1,211,814	1,054,362	157,452	—
Debt securities – State Treasury	21,926	81	21,845	—
Domestic corporate debt securities	532,840	—	532,840	—
Foreign corporate debt securities	96,487	—	96,487	—
Other	177,374	12,216	162,504	2,654
Investments measured using NAV	1,149,370			
Total management-designated cash and investments	$ 4,800,491			
Gift annuities, trusts, and other	$ 53,954	20,454	9,118	24,382
Funds held by trustee:				
Cash and cash equivalents	$ 85,038	85,038	—	—
Domestic equity securities	22,159	22,159	—	—
Foreign equity securities:	1,900	1,900	—	—
Debt securities – U.S. Treasury	84,725	82,125	2,600	—
Domestic corporate debt securities	32,017	—	32,017	—
Foreign corporate debt securities	19,953	—	19,953	—
Mortgage-backed securities	5,956	—	5,956	—
Other	4,090	—	4,090	—
Total funds held by trustee	$ 255,838			

(Continued)

The Health System participates in various funds that are not actively marketed on an open exchange. These investments consist of shares or units in investment funds as opposed to direct interests in the funds' underlying holdings, which may be marketable. Due to the nature of these funds the net asset value per share, or its equivalent, reported by each fund manager is used as a practical expedient to estimate the fair value of the Health System's interest therein. Management believes that the carrying amounts of these financial instruments, provided by the fund managers, are reasonable estimates of fair value.

The following table presents information for investments where the NAV was used to value the investments as of December 31 (in thousands of dollars):

	Fair value		Unfunded Commitments	Redemption frequency	Redemption notice period
	2015	2014			
Hedge funds					
Relative value	$ 180,756	159,753	—	Quarterly	60 – 90 days
Risk parity	155,928	148,543	—	Monthly	5 – 15 days
Growth	169,490	151,218	—	Quarterly	45 – 90 days
Diversified	83,274	85,712	—	Monthly	2 – 90 days
Other	14,613	7,517	—	Monthly or Quarterly	30 – 90 days
Collective investment funds:					
Equities	572,214	522,009	—	Monthly	6 – 60 days
Fixed income	216,243	74,618	—	Daily	3 days
Private equity	8,988	—	75,408	Not applicable	Not applicable
Total	$ 1,401,506	1,149,370	75,408		

The following is a summary of the nature of these investments and their associated risks:

Hedge funds are portfolios of investments that use advanced investment strategies such as leveraged, long, short, and derivative positions in both domestic and international markets with the goal of diversifying portfolio risk and generating return. The Health System's investments in hedge funds include $44,980,000 subject to lockup provisions that limit the Health System's ability to access cash for one or more years from the initial investment.

Collective investment funds are funds that pursue diversification of domestic and foreign equity and fixed income securities. The Health System's investments in collective investment funds have no lockup provisions or other restrictions, other than outlined in the table above, that limit its ability to access cash.

Private equity funds are funds that make opportunistic investments that are primarily private in nature. These investments cannot be redeemed by the Health System; rather the Health System has committed an amount to invest in the private funds over the respective commitment periods. After the commitment period has ended, the nature of the investments in this category is that the distributions are received through the liquidation of the underlying assets.

The Health System offsets the fair value of various investment derivative instruments when executed with the same counterparty under a master netting arrangement. The Health System invests in a variety of investment derivative instruments through a fixed-income manager that has executed a master netting arrangement with the counterparties of each of its futures and forward currency purchase and sale contracts

whereby the financial instruments held by the same counterparty are legally offset as the instruments are settled.

The following table presents gross investment derivative assets and liabilities reported on a net basis included in management-designated investments in the combined balance sheets:

	2015 (In thousands of dollars)
Derivative assets:	
Futures contracts	$ 404,677
Forward currency and other contracts	41,617
	446,294
Derivative liabilities:	
Futures contracts	(404,677)
Forward currency and other contracts	(42,289)
	(446,966)

Investment derivative instruments, reported in management-designated investments in the combined balance sheets, are recorded at fair value.

The Health System's management designated cash and investments include funds held on behalf of non-controlled entities of $59,569,000 and $0 at December 31, 2015 and 2014, respectively. An offsetting liability to recognize the obligation back to the non-controlled entities is included in other liabilities in the accompanying combined balance sheets.

Investment income from management-designated cash and investments and funds held by trustee are included in net nonoperating gains and are comprised of the following for the years ended December 31, 2015 and 2014:

	2015	2014
	(In thousands of dollars)	
Interest income	$ 64,797	71,108
Net realized gains on sale of investments	25,280	365,413
Change in net unrealized losses on trading securities	(203,694)	(258,478)
Total	$ (113,617)	178,043

(Continued)

(5) Property, Plant, and Equipment

Property, plant, and equipment and the total accumulated depreciation at December 31, 2015 and 2014 are shown below:

	Approximate useful life (years)	2015	2014
		(In thousands of dollars)	
Land	—	$ 757,469	756,304
Buildings and improvements	5–60	5,834,374	5,643,827
Equipment:			
Fixed	5–25	1,055,751	1,041,956
Major movable and minor	3–20	4,405,945	4,138,703
Rental property	15–40	914,353	898,609
Construction in progress	—	274,883	216,549
		13,242,775	12,695,948
Less accumulated depreciation		6,661,915	6,073,382
Property, plant, and equipment, net		$ 6,580,860	6,622,566

Construction in progress primarily represents renewal and replacement of various facilities in the Health System's operating divisions, as well as costs capitalized related to software development.

(6) Other Assets

Other assets at December 31, 2015 and 2014 are as follows:

	2015	2014
	(In thousands of dollars)	
Unamortized financing costs, net	$ 34,639	35,744
Investment in nonconsolidated joint ventures	141,182	116,747
Interest in noncontrolled foundations	128,341	136,597
Notes receivable	45,889	37,989
Long-term reinsurance receivable	33,032	39,530
Goodwill and intangibles	169,584	163,540
Other	20,301	38,737
Total other assets	$ 572,968	568,884

The Health System participates in various joint ventures for the purpose of furthering its healthcare mission. These joint ventures exist in all geographic locations in which the Health System operates. The primary purposes of the ventures are to provide outpatient services such as laboratory, outpatient surgery, and medical imaging. Various joint ventures, throughout the Health System, are controlled and consequently are

combined in the financial statements of the Health System. All other joint ventures are accounted for under the equity method of accounting. The Health System recorded earnings from equity method investees of $40,871,000 and $39,159,000 for the years ended December 31, 2015 and 2014, respectively, the majority of which are included in other operating revenues in the accompanying combined statements of operations.

(7) Short-Term and Long-Term Debt

The Health System has borrowed Master Trust debt issued through the following:

- California Health Facilities Financing Authority (CHFFA)
- Alaska Industrial Development and Export Authority (AIDEA)
- Hospital Facilities Authority of Multnomah County (HFAMC)
- Washington Health Care Facilities Authority (WHCFA)
- Montana Facility Finance Authority (MFFA)
- Oregon Facilities Authority (OFA)

(Continued)

Short-term and long-term unpaid principal at December 31, 2015 and 2014 consists of the following:

	Maturing through	Coupon rates	Unpaid principal 2015	Unpaid principal 2014
			(In thousands of dollars)	
Master trust debt:				
Fixed:				
Series 1996, CHFFA Revenue Bonds	2015	4.00 – 6.00%	$ —	2,035
Series 1997, Direct Obligation Notes	2017	7.70%	1,445	2,090
Series 2003H, AIDEA Revenue Bonds	2015	4.63 – 5.25%	—	4,600
Series 2005, Direct Obligation Notes	2030	4.31 – 5.39%	44,380	46,295
Series 2006A, WHCFA Revenue Bonds	2036	4.50 – 5.00%	210,555	210,555
Series 2006B, MFFA Revenue Bonds	2026	4.00 – 5.00%	54,495	58,170
Series 2006C, WHCFA Revenue Bonds	2033	5.25%	69,425	69,425
Series 2006D, WHCFA Revenue Bonds	2033	5.25%	69,275	69,275
Series 2006E, WHCFA Revenue Bonds	2033	5.25%	26,350	26,350
Series 2006H, AIDEA Revenue Bonds	2036	5.00%	51,905	54,355
Series 2008C, CHFFA Revenue Bonds	2038	3.00 – 6.50%	15,785	17,715
Series 2009A, Direct Obligation Notes	2019	5.05 – 6.25%	165,000	165,000
Series 2009B, CHFFA Revenue Bonds	2039	5.50%	150,000	150,000
Series 2010A, WHCFA Revenue Bonds	2039	4.88 – 5.25%	174,240	174,240
Series 2011A, AIDEA Revenue Bonds	2041	5.00 – 5.50%	122,720	122,720
Series 2011B, WHCFA Revenue Bonds	2021	2.00 – 5.00%	58,995	67,390
Series 2011C, OFA Revenue Bonds	2026	3.50 – 5.00%	18,375	20,405
Series 2012A, WHCFA Revenue Bonds	2042	2.00 – 5.00%	497,850	503,955
Series 2012B, WHCFA Revenue Bonds	2042	4.00 – 5.00%	100,000	100,000
Series 2013A, OFA Revenue Bonds	2024	2.00 – 5.00%	66,600	72,515
Series 2013D, Direct Obligation Notes	2023	4.38%	252,285	252,285
Series 2014A, CHFFA Revenue Bonds	2038	2.00 – 5.00%	274,465	275,850
Series 2014B, CHFFA Revenue Bonds	2044	4.25 – 5.00%	118,740	118,740
Series 2014C, WHCFA Revenue Bonds	2044	4.00 – 5.00%	92,245	92,245
Series 2014D, WHCFA Revenue Bonds	2041	5.00%	178,770	178,770
Series 2015A, WHCFA Revenue Bonds	2045	4.00%	77,635	—
Series 2015C, OFA Revenue Bonds	2045	4.00 – 5.00%	71,070	—
Total fixed			2,962,605	2,854,980
Variable:				
Series 2012C, WHCFA Revenue Bonds	2042	0.05%	80,000	80,000
Series 2012D, WHCFA Revenue Bonds	2042	0.05%	80,000	80,000
Series 2012E, Direct Obligation Notes	2042	0.17%	233,525	235,705
Series 2013C, OFA Revenue Bonds	2022	1.08%	135,375	148,750
Series 2013E, Direct Obligation Notes	2017	3.00%	200,000	322,250
Total variable			728,900	866,705

(Continued)

	Maturing through	Coupon rates	Unpaid principal 2015	Unpaid principal 2014
			(In thousands of dollars)	
Commercial Paper, Series 2015B	2016	0.21%	125,000	—
U.S. Bank Credit Facility	2016	0.56%	12,500	12,500
Unpaid principal, master trust debt			3,829,005	3,734,185
Premiums and discounts, net			117,320	123,941
Master trust debt, including premiums and discounts, net			3,946,325	3,858,126
Other long-term debt			165,502	200,923
Total debt			$ 4,111,827	4,059,049

	2015	2014
	(In thousands of dollars)	
Current portion of long-term debt	$ 244,532	202,287
Short-term master trust debt	137,500	12,500
Long-term debt, classified as a long-term liability	3,729,795	3,844,262
Total debt	$ 4,111,827	4,059,049

An Obligated Group was formed for issuing debt under a master trust indenture. Members of the Obligated Group are jointly and severally responsible for all borrowings under the master trust indenture of the Obligated Group. The master trust indenture and bond trust indentures for each debt issue require the Obligated Group to meet certain financial covenants. The members of the Obligated Group include the following:

- Providence Health & Services – Washington (exclusive of Inland Northwest Health Services)
- Western HealthConnect
- Providence Health & Services – Oregon (exclusive of Providence Plan Partners)
- Providence Health System – Southern California (exclusive of Medical Institute of Little Company of Mary, Lifecare Ventures, Inc., TrinityCare Hospice, and Facey)
- Providence St. Joseph Medical Center, and Providence Health & Services – Montana

The Obligated Group excludes related housing projects financed by the U.S. Department of Housing and Urban Development and foundations.

In August and September 2015, the Health System issued $77,635,000 of Series 2015A WHCFA fixed rate revenue bonds and $71,070,000 of Series 2015C OFA fixed rate revenue bonds, respectively. The intended use of funds was to cover certain capital investment.

In November 2014, the Health System issued $178,770,000 of Series 2014D WHCFA fixed rate revenue bonds. The proceeds were used to redeem Series 2006B WHCFA revenue bonds, Series 2006A WHCFA revenue bonds, Series 2010 WHCFA revenue bonds, and Series 2012 WHCFA revenue bonds, which were

issued by Kadlec prior to the affiliation. In connection with the Series 2014D issuance, Kadlec became a member of the Obligated Group.

In September 2014, the Health System issued $92,245,000 of Series 2014C WHCFA fixed rate revenue bonds. The proceeds were used for the partial redemption of Series 2009A PHS Direct Obligation bonds. In connection with the Series 2014C issuance, Swedish Edmonds and PacMed became members of the Obligated Group.

In August 2014, the Health System issued $118,740,000 of Series 2014B CHFFA fixed rate revenue bonds. The proceeds were used to redeem Series 2013F Commercial Paper, which was issued to finance the purchase of Saint John's. In connection with the Series 2014B issuance, Saint John's became a member of the Obligated Group.

In June 2014, the Health System issued $275,850,000 of Series 2014A CHFFA fixed rate revenue bonds. The proceeds were used for the partial redemption of Series 2008C CHFFA bonds.

In connection with the Series 2015A-C issuances and the Series 2014A-D issuances, the Health System recorded losses due to extinguishment of debt of $69,000 and $85,522,000 in 2015 and 2014, respectively, which were recorded in net nonoperating gains in the accompanying combined statements of operations.

(a) Master Trust Debt Classified as Short-Term

Commercial Paper, Series 2015B

In September 2015, the Health System issued Series 2015B commercial paper obligations. During 2015, the Health System made principal and interest payments on matured commercial paper and reissued new commercial paper, maintaining a balance ranging between $27,000,000 and $125,000,000 throughout the year. The average interest rate in effect during 2015 was 0.21%.

U.S. Bank Credit Facility

The Health System has a $150,000,000 Credit Facility with U.S. Bank, of which $12,500,000 in borrowings was outstanding at December 31, 2015 and 2014.

(b) Other Long-Term Debt

Other long-term debt primarily includes capital leases, notes payable, and bonds that are not under the master trust indenture. Other long-term debt at December 31, 2015 and 2014 consists of the following:

	2015	2014
	(In thousands of dollars)	
Capital leases	$ 103,789	114,963
Notes payable	46,988	74,381
Bonds not under master trust indenture and other	14,725	11,579
Total other long-term debt	$ 165,502	200,923

(Continued)

Scheduled principal payments of long-term debt, considering all obligations under the master trust indenture as due according to their long-term amortization schedule, for the next five years and thereafter are as follows:

	Master trust	Other	Total
		(In thousands of dollars)	
2016	$ 221,535	22,997	244,532
2017	160,175	18,825	179,000
2018	62,960	8,800	71,760
2019	165,895	8,074	173,969
2020	68,830	8,092	76,922
Thereafter	3,012,110	98,714	3,110,824
Scheduled principal payments of long-term debt	3,691,505	$ 165,502	3,857,007
Short-term master trust debt	137,500		
Total master trust debt	$ 3,829,005		

Leases

The Health System leases various medical and office equipment and buildings under operating leases. Future minimum lease commitments under noncancelable operating leases for the next five years and thereafter are as follows (in thousands of dollars):

2016	$ 124,188
2017	116,588
2018	103,487
2019	94,394
2020	82,802
Thereafter	613,139
	$ 1,134,598

Rental expense was $216,657,000 and $193,875,000 for the years ended December 31, 2015 and 2014, respectively, and is included in other expenses in the accompanying combined statements of operations.

(8) Retirement Plans

(a) Defined Benefit Plans

Cash Balance Retirement Plan

The Health System had a noncontributory cash balance plan covering substantially all Providence employees called the Providence Health & Services Cash Balance Retirement Plan Trust (the Cash Balance Plan). The plan was frozen effective December 31, 2009. The plan benefits are based on

defined average compensation and years of service. The plan has a five-year cliff vesting schedule. The Health System's funding policy is based on the actuarially determined cost method, and includes normal service cost and prior service costs amortized over a 20-year period. Under the Cash Balance Plan, each employee carries an individual account balance. The Health System makes an annual contribution and provides an annual interest credit to each employee's account.

Supplemental Executive Retirement Plan

The Health System has a noncontributory supplemental executive retirement plan (the SERP) covering certain employees who were employed in certain key positions or pay grades or that have been designated by the Health System. The plan was frozen effective December 31, 2009. The plan benefits were based on defined average compensation and years of service. The vesting period for the plan requires an executive attain age 55 with at least five years of eligible service. The Health System's funding policy is based on the actuarially determined cost method, and includes normal service cost and prior service costs amortized over a 20-year period. Under the SERP, each employee carries an individual account balance. The Health System makes an annual contribution and provides an annual interest credit to each employee's account.

Swedish Health Services Pension Plan

The Swedish Health Services Pension Plan (the Pension Plan) is a noncontributory plan covering a majority of Swedish employees, and provides benefits based on number of years of credited service and compensation earned during the participation in the Pension Plan. The Pension Plan is frozen to all former and existing nonrepresented employees and to all new participants. Only represented employees that were active in the plan on December 31, 2009 remain in the plan actively accruing benefits. The Health System makes annual contributions to the Pension Plan.

Willamette Falls Pension Plan

The Willamette Falls Pension Plan is also a noncontributory plan covering a majority of employees at Providence Willamette Falls. The plan was frozen effective February 2008. The plan benefits are based on years of service and compensation during an employee's period of employment. The funding policy is based on the actuarially determined cost method, and includes normal service cost and prior service costs amortized over a 20-year period. Under the Willamette Falls Pension Plan, each employee carries an individual monthly annuity benefit.

The Cash Balance Plan, the SERP, the Pension Plan, and the Willamette Falls Pension Plan are collectively "the defined benefit plans."

The Health System's contributions to these defined benefit plans for the years ended December 31, 2015 and 2014 were $90,562,000 and $100,380,000, respectively.

(Continued)

The measurement dates for the defined benefit plans are December 31, 2015 and 2014. A rollforward of the change in benefit obligation and change in the fair value of plan assets for the defined benefit plans is as follows:

	2015	2014
	(In thousands of dollars)	
Change in projected benefit obligation:		
Projected benefit obligation at beginning of year	$ 2,827,325	2,592,617
Service cost	24,858	22,851
Interest cost	113,956	124,911
Actuarial (gain) loss	(134,753)	289,225
Benefits paid and other	(231,159)	(202,279)
Projected benefit obligation at end of year	2,600,227	2,827,325
Change in fair value of plan assets:		
Fair value of plan assets at beginning of year	1,782,250	1,773,628
Actual return on plan assets	(106,400)	110,521
Employer contributions	90,562	100,380
Benefits paid and other	(231,159)	(202,279)
Fair value of plan assets at end of year	1,535,253	1,782,250
Funded status	(1,064,974)	(1,045,075)
Unrecognized net actuarial loss	470,429	441,783
Unrecognized prior service cost	5,068	6,299
Net amount recognized	$ (589,477)	(596,993)
Amounts recognized in the consolidated balance sheets consist of:		
Current liabilities	$ (1,393)	(4,136)
Noncurrent liabilities	(1,063,581)	(1,040,939)
Unrestricted net assets	475,497	448,082
Net amount recognized	$ (589,477)	(596,993)
Weighted average assumptions:		
Discount rate	4.58%	4.20%
Rate of increase in compensation levels	3.50	3.50
Long-term rate of return on assets	6.80	7.00

(Continued)

Net periodic pension cost for the defined benefit plans for 2015 and 2014 includes the following components:

	2015	2014
	(In thousands of dollars)	
Components of net periodic pension cost:		
Service cost	$ 24,858	22,851
Interest cost	113,956	124,911
Expected return on plan assets	(115,711)	(118,676)
Amortization of prior service cost	1,231	1,231
Recognized net actuarial loss	26,163	14,340
Settlement expense	32,549	32,798
Net periodic pension cost	$ 83,046	77,455

Total expense for all of the Health System's defined benefit plans for the years ended December 31, 2015 and 2014 was $83,046,000 and $77,455,000, respectively. Included in the total expense is $32,549,000 and $32,798,000 of settlement costs that were incurred in 2015 and 2014, respectively, related to settlements that were greater than the sum of the service cost and interest cost components of net periodic pension cost. This settlement expense is included in net nonoperating gains in the accompanying combined statements of operations. The remaining expense for the defined benefit plans is included in employee benefits in the accompanying combined statements of operations.

The accumulated benefit obligation was $2,555,741,000 and $2,771,511,300 at December 31, 2015 and 2014, respectively.

The following pension benefit payments reflect expected future service. Payments expected to be paid over the next 10 years are as follows (in thousands of dollars):

2016	$ 194,339
2017	176,086
2018	186,764
2019	192,506
2020 – 2025	1,104,643
	$ 1,854,338

The Health System expects to contribute approximately $71,600,000 to the defined benefit plans in 2016.

The expected long-term rate of return on plan assets is the expected average rate of return on the funds invested currently and on funds to be invested in the future in order to provide for the benefits included in the projected benefit obligation. The Health System used 6.8% and 7.0% in calculating the 2015 and 2014 expense amounts, respectively. This assumption is based on capital market assumptions and the plan's target asset allocation.

(Continued)

The Health System continues to monitor the expected long-term rate of return. If changes in those parameters cause 6.8% to be outside of a reasonable range of expected returns, or if actual plan returns over an extended period of time, suggest that general market assumptions are not representative of expected plan results, the Health System may revise this estimate prospectively.

Target asset allocation and expected long-term rate of return on assets (ELTRA) for the years ended December 31, 2015 and 2014, respectively, were as follows:

	2015 Target	2015 ELTRA	2014 Target	2014 ELTRA
Cash and cash equivalents	2%	1% – 3%	5%	1% – 4%
Equity securities	47	5% – 8%	35	5% – 8%
Debt securities	35	2% – 6%	50	3% – 5%
Other securities	16	5% – 8%	10	6% – 9%
Total	100%	6.80%	100%	7.00%

(Continued)

The following table presents the Health System's defined benefit plan assets measured at fair value at December 31, 2015:

	December 31, 2015	Fair value measurements at reporting date using		
		Level 1	Level 2	Level 3
		(In thousands of dollars)		
Assets:				
Cash and cash equivalents	$ 38,530	38,530	—	—
Domestic equity securities:				
Mutual funds:				
Large capitalization	16,180	16,180	—	—
Technology	63,668	63,668	—	—
Financial services	52,988	52,988	—	—
Consumer services	48,814	48,814	—	—
Other	96,105	96,105	—	—
Foreign equity securities:				
Mutual funds:				
Large capitalization	14,487	14,487	—	—
Consumer services	14,216	14,216	—	—
Technology	10,693	10,693	—	—
Other	11,983	11,983	—	—
Debt securities – state and government	242,808	169,396	73,412	—
Foreign securities – state and government	7,500	—	7,500	—
Domestic corporate debt securities	115,999	—	115,999	—
Foreign corporate debt securities	15,095	—	15,095	—
Other	7,781	—	7,781	—
Investments measured using NAV	778,406			
Total	$ 1,535,253			

(Continued)

The following table presents the Health System's defined benefit plan assets measured at fair value at December 31, 2014:

	December 31, 2014	Fair value measurements at reporting date using		
		Level 1	Level 2	Level 3
		(In thousands of dollars)		
Assets:				
Cash and cash equivalents	$ 44,670	44,670	—	—
Domestic equity securities:				
Mutual funds:				
Medium-small cap and other	2,252	2,252	—	—
Consumer services	184,842	184,842	—	—
Financial services	68,769	68,769		
Technology	45,304	45,304	—	—
Other	62,558	62,558	—	—
Foreign equity securities:				
Mutual funds:				
Large capitalization	44,450	44,450	—	—
Consumer services	15,809	15,809	—	—
Technology	11,777	11,777	—	—
Other	19,809	19,809	—	—
Debt securities – state and government	281,432	208,804	72,628	—
Foreign securities – state and government	14,596	—	14,596	—
Domestic corporate debt securities	129,564	—	129,564	—
Foreign corporate debt securities	22,291	—	22,291	—
Other	13,108	3,246	9,862	—
Investments measured using NAV	821,019			
Total	$ 1,782,250			

The Health System defined benefit plans participate in various funds that are not actively marketed on an open exchange. These investments consist of shares or units in investment funds as opposed to direct interests in the funds' underlying holdings, which may be marketable. Due to the nature of these funds the net asset value per share, or its equivalent, reported by each fund manager is used as a practical expedient to estimate the fair value of the Health System's interest therein. Management believes that the carrying amounts of these financial instruments, provided by the fund managers, are reasonable estimates of fair value.

(Continued)

The following table presents information for investments where either the NAV per share or its equivalent was used to value the investments as of December 31:

	Fair value 2015	Fair value 2014	Redemption frequency	Redemption notice period
Hedge funds				
Risk parity	$ 125,398	138,886	Monthly	5 – 15 days
Growth	142,320	140,305	Quarterly	45 – 90 days
Other	1,444	2,993	Monthly or Quarterly	30 – 90 days
Collective investment funds:				
Equities	355,462	349,662	Monthly	6 – 60 days
Fixed income	153,782	189,173	Daily	3 days
Total	$ 778,406	821,019		

There were no significant transfers between assets classified as Level 1 and Level 2 during the years ended December 31, 2015 and 2014.

(b) Defined Contribution Plans

401(a) Service Plan

The Health System sponsors the Providence Health & Services 401(a) Service Plan (the Service Plan). The Service Plan covers substantially all Providence employees, with contributions based on defined eligible compensation and years of service. The plan has a five-year cliff vesting schedule. The Health System contributed $153,563,000 to the Service Plan in 2015 related to prior years, and has accrued a liability of $161,947,000 as of December 31, 2015 related to contributions to be made in 2016 for plan year 2015. The accrued balance has been included in the current portion of retirement plan obligations on the accompanying combined balance sheets.

403(b) Value Plan

The Health System also sponsors the Providence Health & Services 403(b) Value Plan (the Value Plan). The plan is a defined contribution plan, which includes a qualified cash or deferred arrangement, for the benefit of eligible employees. Vesting is immediate. Total Value Plan expense, primarily related to contributions, was $77,070,000 and $74,760,000 in 2015 and 2014, respectively, and is included in employee benefits expense in the accompanying combined statements of operations.

Providence, Swedish, PAML Multiple Employer 401(k) Plan

The Health System sponsors the Providence, Swedish, PAML Multiple Employer 401(k) Plan which covers certain Providence affiliates unable to participate in the Service Plan and the Value Plan. The plan is a defined contribution plan with contributions based on defined eligible compensation. The plan has a four-year cliff vesting schedule. Total plan expense, primarily related to contributions, was $47,590,000 and $42,781,000 in 2015 and 2014, respectively, and is included in employee benefits expense in the accompanying combined statements of operations.

(Continued)

(9) Self-Insurance Liability

The Health System has established self-insurance programs for professional and general liability and workers' compensation insurance coverage. These programs provide insurance coverage for healthcare institutions associated with the Health System. The Health System also operates an insurance captive, Providence Assurance, Inc., to self-insure or reinsure certain layers of professional and general liability risk.

The Health System accrues estimated self-insured professional and general liability and workers' compensation insurance claims based on management's estimate of the ultimate costs for both reported claims and actuarially determined estimates of claims incurred-but-not-reported. Insurance coverage in excess of the per occurrence self-insured retention, has been secured with insurers or reinsurers for specified amounts for professional, general, and workers' compensation liabilities. Decisions relating to the limit and scope of the self-insured layer and the amounts of excess insurance purchased are reviewed each year, subject to management's analysis of actuarial loss projections and the price and availability of acceptable commercial insurance.

At December 31, 2015 and 2014, the estimated liability for future costs of professional and general liability claims was $249,013,000 and $232,639,000, respectively. At December 31, 2015 and 2014, the estimated workers' compensation obligation was $162,728,000 and $150,845,000, respectively, in the accompanying combined balance sheets. At December 31, 2015 and 2014, $292,843,000 and $274,541,000, respectively, of these amounts were included as self-insurance liability, net of current portion, with the remainder included within current portion of self-insurance liability, in the accompanying combined balance sheets.

(10) Commitments

Firm purchase commitments, primarily related to construction, software, and supplies, at December 31, 2015, are approximately $163,590,000.

(11) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at December 31, 2015 and 2014:

	2015	2014
	(In thousands of dollars)	
Program support	$ 184,340	160,842
Low-income housing	32,950	34,036
Capital acquisition and other	107,601	110,399
Total temporarily restricted net assets	$ 324,891	305,277

The Health System's fundraising foundations have obtained contributions to support the various programs offered by the Health System. Many of these contributions remain temporarily restricted as of December 31, 2015 and 2014 because the time or purpose restrictions stipulated by the donor have not been met. Generally, program support consists of items that will defray the cost of operating certain patient care activities of the Health System.

(Continued)

Other revenues included $48,228,000 and $48,589,000 of assets released from restriction for operations for the years ended December 31, 2015 and 2014, respectively.

Permanently restricted net assets are restricted to investments in perpetuity, the income of which is expendable primarily for program support.

(12) Litigation and Contingencies

The healthcare industry is subject to numerous laws and regulations from federal, state, and local governments. Compliance with these laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time. Government monitoring and enforcement activity continues with respect to investigations and allegations concerning possible violations by healthcare providers of regulations, which could result in the imposition of significant fines and penalties, as well as significant repayments of patient services previously billed. Institutions within the Health System are subject to similar regulatory reviews.

Management is aware of certain asserted and unasserted legal claims and regulatory matters arising in the course of business. After consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on the Health System's combined financial statements.

(13) Functional Expenses

The Health System provides healthcare services to residents within its geographic service areas. Expenses related to providing these services for the years ended December 31, 2015 and 2014 are as follows:

	2015	2014
	(In thousands of dollars)	
Healthcare expenses	$ 10,700,175	9,199,881
Purchased healthcare expenses	1,045,019	909,154
General and administrative expenses	2,426,771	2,152,790
Total operating expenses	$ 14,171,965	12,261,825

Schedule 1

PROVIDENCE HEALTH & SERVICES

Supplemental Schedule – Balance Sheet Information

December 31, 2015 (with combined totals for 2014)

(In thousands of dollars)

Assets	Alaska	Washington	Montana	Oregon	Providence Plan Partners	Southern California	System office, eliminations, and other	2015 Total Health System	2014 Total Health System
Current assets:									
Cash and cash equivalents	$ 213,952	191,084	7,779	207,553	74,695	(113,363)	147,621	729,321	1,237,337
Short-term management-designated investments	—	—	—	—	—	18,721	181,530	200,251	199,338
Accounts receivable, net	160,005	815,096	51,729	319,025	—	298,333	(74,361)	1,569,827	1,419,495
Other receivables, net	20,088	939,747	82,816	98,241	53,994	109,741	(905,336)	399,291	375,185
Supplies inventory	12,605	85,491	5,991	37,507	—	28,461	24,564	194,619	185,821
Other current assets	1,090	33,651	247	22,443	3,803	24,030	55,572	140,836	203,337
Current portion of funds held by trustee	76	2,672	1	1,478	—	64	50,449	54,740	76,365
Total current assets	407,816	2,067,741	148,563	686,247	132,492	365,987	(519,961)	3,288,885	3,696,878
Assets whose use is limited:									
Management-designated cash and investments	523,467	1,350,622	47,682	1,204,626	570,946	218,945	1,014,570	4,930,858	4,601,153
Gift annuities, trusts, and other	360	16,366	2,351	27,886	—	15,116	31,725	93,804	53,954
Funds held by trustee	—	66,617	—	68,371	15,793	350	121,771	272,902	179,473
Assets whose use is limited, net	523,827	1,433,605	50,033	1,300,883	586,739	234,411	1,168,066	5,297,564	4,834,580
Property, plant, and equipment, net	552,020	3,065,950	94,018	1,030,286	69,003	1,025,488	744,095	6,580,860	6,622,566
Other assets	26,746	241,655	21,127	61,618	1,381	230,317	(9,876)	572,968	568,884
Total assets	$ 1,510,409	6,808,951	313,741	3,079,034	789,615	1,856,203	1,382,324	15,740,277	15,722,908
Liabilities and Net Assets									
Current liabilities:									
Current portion of long-term debt	$ 26,748	99,844	4,179	40,312	—	30,569	42,880	244,532	202,287
Master trust debt classified as short-term	—	—	—	—	—	—	137,500	137,500	12,500
Accounts payable	14,237	198,078	12,596	58,642	1,657	100,033	42,324	427,567	521,942
Accrued compensation	24,888	224,403	10,118	108,782	—	71,063	202,152	641,406	738,075
Payable to contractual agencies	5,742	51,047	122	3,812	2,952	8,168	32,808	104,651	151,778
Retirement plan obligations	—	—	—	—	—	—	190,278	190,278	185,517
Current portion of self-insurance liability	—	10,802	—	—	—	—	108,096	118,898	108,943
Other current liabilities	4,833	1,068,887	79,540	94,507	288,701	119,630	(1,192,900)	463,198	465,865
Total current liabilities	76,448	1,653,061	106,555	306,055	293,310	329,463	(436,862)	2,328,030	2,386,907
Long-term debt, net of current portion (1)	253,626	2,164,345	52,037	292,987	—	671,023	295,777	3,729,795	3,844,262
Other long-term liabilities	21,773	454,702	6,380	45,460	1,382	65,524	1,051,583	1,646,804	1,542,579
Total liabilities	351,847	4,272,108	164,972	644,502	294,692	1,066,010	910,498	7,704,629	7,773,748
Net assets:									
Unrestricted	1,145,988	2,409,856	142,933	2,326,791	494,923	639,972	426,316	7,586,779	7,537,626
Temporarily restricted	9,668	91,567	3,973	71,771	—	110,599	37,313	324,891	305,277
Permanently restricted	2,906	35,420	1,863	35,970	—	39,622	8,197	123,978	106,257
Total net assets	1,158,562	2,536,843	148,769	2,434,532	494,923	790,193	471,826	8,035,648	7,949,160
Total liabilities and net assets	$ 1,510,409	6,808,951	313,741	3,079,034	789,615	1,856,203	1,382,324	15,740,277	15,722,908

(1) The Obligated Group debt is joint and several for the Obligated Group members, however, the balance sheets of the individual entities only include their allocated portions.

See accompanying independent auditors' report.

Schedule 2

PROVIDENCE HEALTH & SERVICES

Supplemental Schedule – Statement of Operations Information

December 31, 2015 (with combined totals for 2014)

(In thousands of dollars)

	Alaska	Washington	Montana	Oregon	Providence Plan Partners	Southern California	System office, eliminations, and other	2015 Total Health System	2014 Total Health System
Operating revenues:									
Net patient service revenues	$ 836,680	6,218,533	352,193	2,778,202	—	2,302,762	(519,254)	11,969,116	10,294,637
Provision for bad debts	(24,946)	(77,864)	(5,092)	(6,163)	—	(67,149)	(4,353)	(185,567)	(193,018)
Net patient service revenues less provision for bad debts	811,734	6,140,669	347,101	2,772,039	—	2,235,613	(523,607)	11,783,549	10,101,619
Premium and capitation revenues	—	181,793	—	96,362	1,330,926	253,155	—	1,862,236	1,682,968
Other revenues	51,996	314,105	26,771	263,283	79,623	113,959	(61,741)	787,996	696,390
Total operating revenues	863,730	6,636,567	373,872	3,131,684	1,410,549	2,602,727	(585,348)	14,433,781	12,480,977
Operating expenses:									
Salaries and wages	270,356	2,648,830	120,575	1,199,743	2,920	885,997	855,298	5,983,719	5,248,196
Employee benefits	24,395	368,935	10,693	117,004	17	80,075	756,584	1,357,703	1,220,078
Purchased healthcare	—	90,852	—	30,800	1,270,029	97,412	(444,074)	1,045,019	909,154
Professional fees	19,041	159,648	17,401	74,346	25,505	240,884	45,775	582,600	514,990
Supplies	111,607	1,015,985	73,416	518,569	659	318,183	33,586	2,072,005	1,792,707
Purchased services	53,791	407,247	38,484	154,627	146,166	166,111	138,763	1,105,189	977,247
Depreciation	54,600	263,881	11,263	107,851	2,098	70,778	120,066	630,537	676,357
Interest	14,725	86,479	2,689	5,994	—	32,617	10,976	153,480	155,343
Amortization	(12)	(1,045)	438	(325)	—	746	918	720	5,671
Other	24,528	498,491	14,186	194,265	38,759	293,719	177,045	1,240,993	762,082
Total operating expenses	573,031	5,539,303	289,145	2,402,874	1,486,153	2,186,522	1,694,937	14,171,965	12,261,825
Excess (deficit) of revenues over expenses from operations	290,699	1,097,264	84,727	728,810	(75,604)	416,205	(2,280,285)	261,816	219,152
Net nonoperating (losses) gains	(4,485)	(45,752)	226	(28,337)	7,855	(17,580)	(96,918)	(184,991)	552,270
Excess (deficit) of revenues over expenses	286,214	1,051,512	84,953	700,473	(67,749)	398,625	(2,377,203)	76,825	771,422
Net assets released from restriction for capital	109	7,027	(92)	2,618	—	9,622	1,088	20,372	13,646
Change in noncontrolling interests in consolidated joint ventures	(73)	(397)	—	(804)	—	(819)	1,695	(398)	584
Pension related changes	—	(19,156)	—	1,263	—	—	(9,522)	(27,415)	(249,011)
Interdivision transfers	(171,911)	(954,602)	(79,776)	(685,019)	—	(480,719)	2,372,027	—	—
Contributions, grants, and other	(3,497)	(8,491)	10	(2,769)	—	(4,073)	(1,411)	(20,231)	(8,639)
Increase (decrease) in unrestricted net assets	$ 110,842	75,893	5,095	15,762	(67,749)	(77,364)	(13,326)	49,153	528,002

See accompanying independent auditors' report.

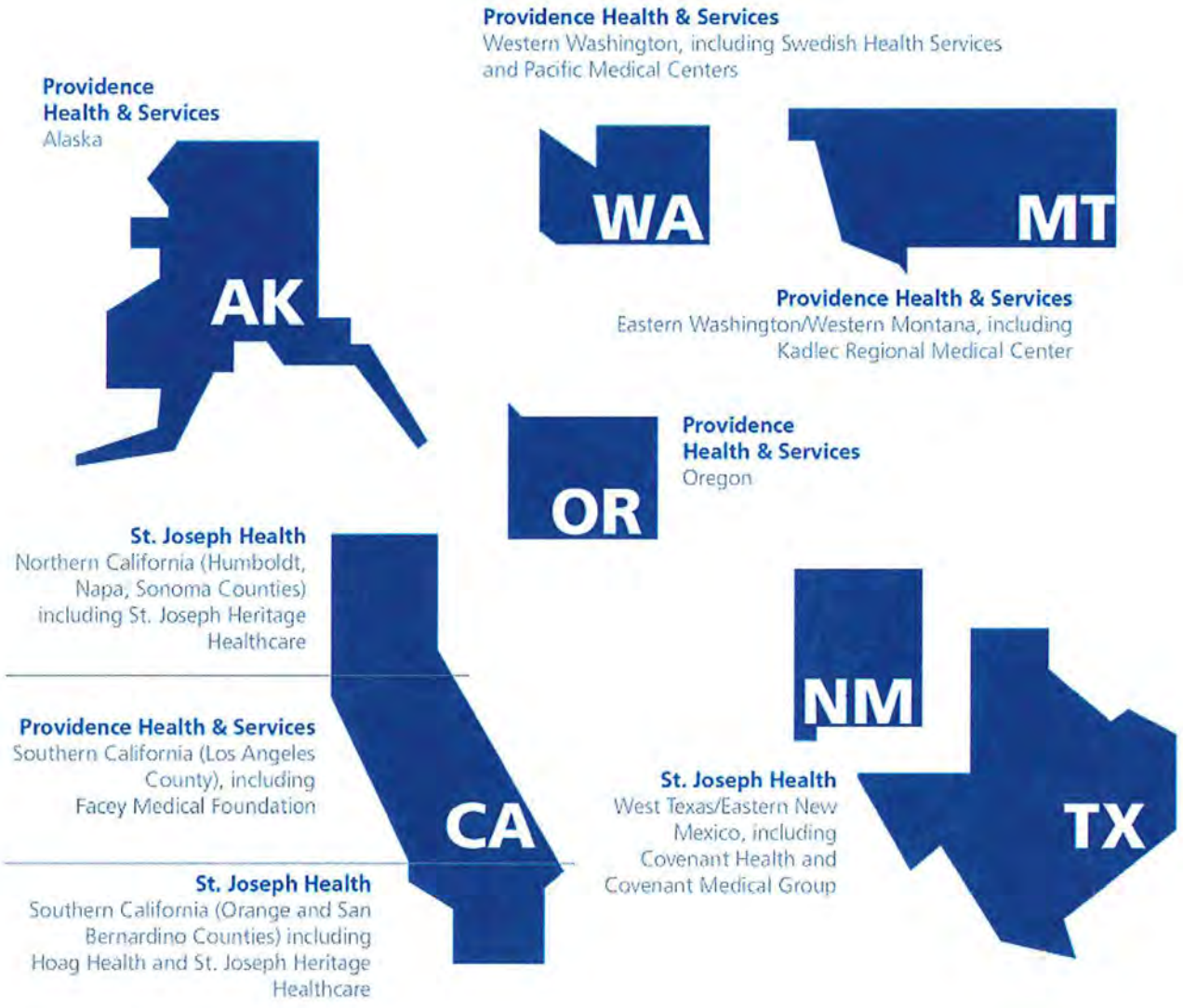
Providence St. Joseph Health

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

Year ended December 31, 2016

About Providence St. Joseph Health

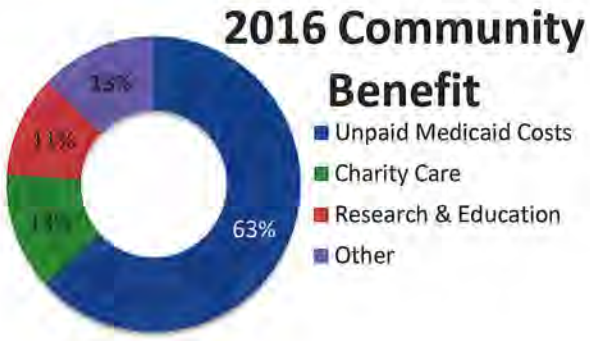
Effective July 1, 2016, Providence Health & Services and St. Joseph Health came together to serve more people in a partnership that joins two remarkable organizations with rich heritages. We are now connected by a new parent organization, Providence St. Joseph Health. Together, over 100,000 of our caregivers (employees) now serve in 50 hospitals, over 800 clinics and a comprehensive range of health and social services across Alaska, California, Montana, New Mexico, Oregon, Texas and Washington. All hospitals and other ministries will maintain their current names and identities. This parent structure allows our family of diverse organizations to work together to meet the needs of our communities both today and into the future.



Investing in our communities to improve health and increase access

Providence St. Joseph Health provided $1.6 billion in community benefit in 2016. Through programs and donations, health education, free care, medical research and more, our community benefit investments fulfill unmet needs in communities we serve across seven states.

In an environment of decreased reimbursement for government-sponsored medical care, community benefit spending related to the unpaid costs of Medicaid was more than $1 billion through the fourth quarter of 2016. Answering the call of our Mission to care for everyone, regardless of their ability to pay, we offered more than $210 million in free and discounted care for those in need.



Advocating for important health and social programs

We believe health care is a basic human right and are committed to expanded coverage that gives access to affordable care for all. With a special focus on serving those who are poor and vulnerable, we advocate for policies that will improve the health of entire communities and further facilitate innovation in care and payment models. During 2016 we helped advance legislation that supports primary care, care management and cognitive services, telehealth services and new care and payment models in Medicaid and Medicare.

Our commitment to mental health

In honor of the 143,000 caregivers, physicians, volunteers and board members who make up Providence St. Joseph Health, the System donated $1.43 million to organizations focused on improving awareness and care for those with mental illness. Donations were made to the Mental Health First Aid program, sponsored by the National Council for Behavioral Health, and the National Alliance on Mental Illness Family-to-Family program. The funds will support the training of more than 50,000 people living and working in Providence St. Joseph Health communities on skills such as understanding the signs of mental illness.

We also announced the Institute for Mental Health and Wellness' first chief executive, Tyler Norris, MDiv. The institute was founded as part of a larger commitment by Providence St. Joseph Health to address the growing mental health crisis in the U.S. The System made an initial seed endowment of $100 million to support advances in behavioral health, including awareness, diagnosis and treatment. In his new role, Norris will shape the institute's vision and strategic direction through community-based collaborations and partnerships.

Leading dynamic change through innovation

Extending relationships between episodes of care

Providence St. Joseph Health's Digital and Innovation Division aims to build meaningful relationships and serve as valuable partners in health. The group tests consumer innovations that are adjacent to our health care services and improve overall community health. Through these innovations, we decrease our population risk by creating a continuous relationship with consumers between episodes of care.

We are currently running new services in women's health (Circle™) and senior services (Optimal Aging™). The Circle™ women and children's app is built on a personalization platform which provides trusted answers to frequently asked questions about maternal and pediatric health. This service enables families to connect to the System and community resources conveniently, and is deploying across the System in 2017. Optimal Aging™ provides seniors affordable access to transportation, meals, home care, home maintenance and social connections. This service fulfills goals to support seniors' day-to-day living, improve the safety of their homes, and provide trusted planning and advice about aging optimally. Optimal Aging™ is currently is available in King and Snohomish counties, Wash., and looks forward to expanding to Portland, Ore. in 2017.

Introduction to Management's Discussion and Analysis

Management's discussion and analysis provides additional narrative explanation of the financial condition, operational results and cash flow of the System to increase understanding of the combined financial statements. The following information should be read in conjunction with the audited combined financial statements and related footnotes.

System overview

Effective July 1, 2016, Providence St. Joseph Health, a Washington nonprofit corporation, became the sole member of both Providence Health & Services, a Washington nonprofit corporation, and St. Joseph Health, a California nonprofit public benefit corporation, each of which were a multi-state health system, creating one of the largest health care systems in the United States. The System, headquartered in Renton, Washington, is structured with a centralized operating model and governed by a co-sponsorship council made up of members of its two sponsoring ministries, Providence Ministries and St. Joseph Health Ministry.

Providence Health & Services has a fiscal year ending December 31, and St. Joseph Health has a fiscal year ending June 30. The System has adopted a fiscal year ending December 31. To enable certain financial results to be presented on a consistent basis, notwithstanding the difference in fiscal years, unaudited pro forma combined financial results of the System are presented for the twelve-month periods ended December 31, 2016 and 2015.

Financial performance

The results discussed in this document are presented on a pro forma basis for the System. Data was derived by combining the consolidated year-to-date results of Providence Health & Services and St. Joseph Health assuming that operations of the two organizations were combined as of January 1, 2015. Certain immaterial adjustments have been made to conform financial statement presentations. Pro forma data includes the impact of affiliation related transactions, such as asset write-ups and the related amortization/depreciation of these assets, prior to the affiliation date of July 1, 2016. Management believes this pro forma data is the most useful presentation for evaluating and discussing current year operations in comparison to the prior year.

Year-to-date results

Balance Sheet	Providence St. Joseph Health (Pro Forma)			
PRESENTED IN MILLIONS	12-31-16	12-31-2015	12 MONTH CHANGE	CHANGE %
Current Assets:				
Cash and Cash Equivalents	782	885	(103)	(12%)
Short-term Management Designated Investments	875	1,139	(264)	(23%)
Accounts Receivable, Net	2,206	2,153	53	2%
Other Current Assets	1,449	1,047	402	38%
Current Portion of Funds Held by Trustee	109	55	54	98%
Total Current Assets	**5,421**	**5,279**	**142**	**3%**
Assets Whose Use is Limited:				
Management Designated Cash and Investments	8,091	7,361	730	10%
Funds Held by Trustee, Gift, Annuity, and Other	641	512	129	25%
Total Assets Whose Use is Limited	**8,731**	**7,873**	**858**	**11%**
Property, Plant & Equipment	**11,022**	**10,477**	**545**	**5%**
Total Other Assets	**1,118**	**1,220**	**(102)**	**(8%)**
Total Assets	**26,292**	**24,849**	**1,443**	**6%**
Current Liabilities:				
Short-term Debt and Current Portion of Long-term Debt	353	471	(118)	(25%)
Accounts Payable	584	555	29	5%
Accrued Compensation	1,104	924	180	19%
Other Current Liabilities	1,911	1,446	465	32%
Total Current Liabilities	**3,952**	**3,396**	**556**	**16%**
Long-Term Debt, Net of Current Portion	6,396	6,009	387	6%
Other Long-term Liabilities	2,149	2,039	110	5%
Total Liabilities	**12,497**	**11,444**	**1,053**	**9%**
Net Assets:				
Unrestricted	12,759	12,539	220	2%
Restricted Net Assets	1,035	866	169	20%
Total Net Assets	**13,795**	**13,405**	**390**	**3%**
Total Liabilities and Net Assets	**26,292**	**24,849**	**1,443**	**6%**

Statement of Operations	Providence St. Joseph Health (Pro Forma)			
DATA PRESENTED YEAR TO DATE; $ FIGURES PRESENTED IN MILLIONS	2016 ACTUAL	2015 ACTUAL	VARIANCE	VARIANCE %
Net Patient Revenue	17,296	16,575	721	4%
Premium and Capitation Revenue	3,773	3,116	657	21%
Other Revenue	1,088	1,050	38	4%
Total Revenue	**22,157**	**20,741**	**1,416**	**7%**
Salaries and Wages	8,926	8,145	781	10%
Depreciation	1,036	997	39	4%
Interest and Amortization	265	260	5	2%
Other Expenses	12,185	11,058	1,127	10%
Total Operating Expenses	**22,412**	**20,460**	**1,952**	**10%**
Excess of Revenues Over Expenses from Operations	**(255)**	**281**	**(536)**	**(191%)**
Net Nonoperating Gains (Losses)	5,485	(248)	5,733	(2312%)
Excess of Revenues Over Expenses	**5,230**	**33**	**5,197**	**15748%**
Operating EBIDA	**1,046**	**1,537**	**(491)**	**(32%)**

Key Financial Indicators	Providence St. Joseph Health (Pro Forma)			
DATA PRESENTED YEAR TO DATE; $ FIGURES PRESENTED IN MILLIONS	2016 ACTUAL	2015 ACTUAL	YTD VAR	YTD VAR %
Operating Margin %	(1.2)	1.4	(2.6)	(186%)
Operating EBIDA Margin %	4.7	7.4	(2.7)	(36%)
Total Community Benefit	1,632	1,445	187	13%
Net Service Revenue / Case Mix Adj Admits (whole value)	11,817	12,118	(301)	(2%)
Expense/Case Mix Adj Admits	11,976	11,932	44	0%
FTEs (presented in thousands)	102	96	6	6%

Lower reimbursement for services from changes in payor mix, payment rates and procedure mix remains the most significant challenge for the System. While volumes have continued to grow in comparison to the prior year, this growth has correlated with a higher percentage of Medicaid patients and increases in acuity levels as measured by case mix index. In addition to reimbursement challenges, the System has been facing increasing labor and supply costs. A competitive labor market has led to higher wage costs and increased vacancy, resulting in greater utilization and rates of agency staffing. These industry challenges have exerted financial pressure on the System, resulting in a year-to-date operating loss of $255 million.

Net income included a net gain of $5.1 billion in 2016 from the affiliation inherent contribution and one-time debt refinancing, which was primarily driven by the St. Joseph Health affiliation and subsequent debt restructuring. The inherent contribution is the result of the affiliation being a non-cash transaction. With the impact of the affiliation inherent contribution and debt refinancing removed, year-to-date net income was $122 million, up from $33 million in the prior year. The increase in adjusted net income was primarily the result of current year investment gains of $493 million, partially offset by operating losses and innovation related expenses.

Volumes

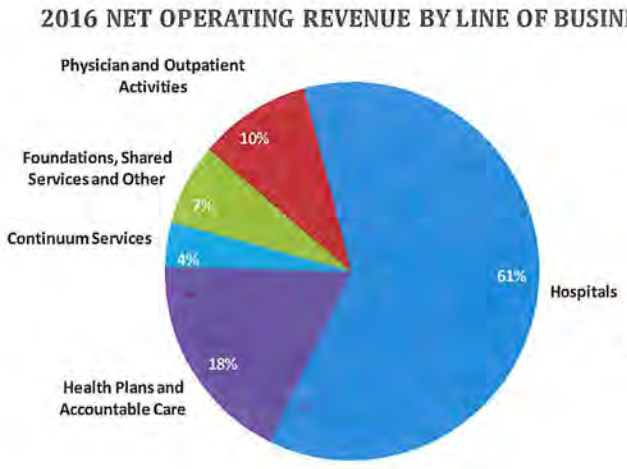
Key Volume Indicators	Providence St. Joseph Health (Pro Forma)			
DATA PRESENTED YEAR TO DATE; IN THOUSANDS UNLESS NOTED	2016 ACTUAL	2015 ACTUAL	YTD VAR	YTD VAR %
Inpatient Admissions	526	519	7	1%
Acute Adjusted Admissions	989	957	32	3%
Outpatient Visits	24,352	22,875	1,477	6%
Total Surgeries	567	545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

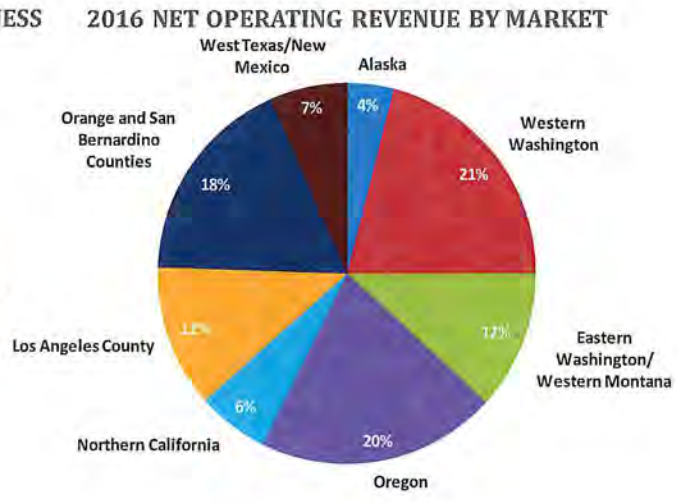
While the System has experienced volumes growth in 2016, trends in this growth have been highly influenced by the effects of the Affordable Care Act. Specifically, growth has been highest amongst Medicaid patients with an overall higher acuity level, which require additional resources to serve. Additionally, the System has experienced increases in ambulatory services at a rate that largely outpaced growth in acute and inpatient services. This increase in physician visits was attributed to employment of new physicians and advanced care practitioners in 2016, in addition to increased panel sizes for clinicians hired in 2015. Clinic expansion also continued through our partnership with Walgreens, opening 25 new clinics in 2016.

Surgery volumes also experienced higher growth in the outpatient setting as compared to the inpatient setting. Year-to-date inpatient surgeries increased 1 percent, while outpatient increased 6 percent as compared to the same period of 2015. Surgery increases are partially attributed to an exclusive contract with Group Health in Washington to provide inpatient services as well as improvements in integrated care networks.

The Providence Health Plan enrollment growth has continued in 2016 through an expansion of services and coverage. Year-to-date connected lives member months, a measure of coverage for insured members, increased from 6.1 million member months in 2015 to 7.5 million member months in 2016.

Operating Revenue





Year-to-date operating revenue of $22.2 billion was 7 percent greater than the prior year. Approximately half of the increase was driven by a 21 percent rise in capitated and premium revenue. Total premium revenue of $2.8 billion was 41 percent higher than prior year as health plan member enrollment increased in 2016. Premium revenue grew at a slower rate than membership as a result of changes in business line mix. Capitated and premium revenue now represents 17 percent of the System's total operating revenue as compared to 15 percent in the prior year.

Patient service revenue grew by 4 percent which was less than the 6 percent volume increase as measured by case mix adjusted admissions. The lower service revenue growth was driven by changes in payor mix, payment rates and procedure mix. While higher acuity as measured by case mix index generally results in higher reimbursement, related increases in revenue were offset by unfavorable shifts in payor mix. Medicaid and Medicare revenues as a percentage of total net revenue grew by 1 percent to become 48 percent of the acute business.

Payor Mix -Net Patient Revenue	Providence St. Joseph Health (Pro Forma)			
DATA PRESENTED YEAR TO DATE;	2016 ACTUAL	2015 ACTUAL	YTD VAR	YTD VAR %
Commercial	51%	51%	0%	0%
Medicare	32%	31%	1%	3%
Medicaid	16%	16%	0%	0%
Self-pay	2%	1%	1%	100%
Other	(1%)	1%	(2%)	0%

Operating expenses

Year-to-date operating expenses grew by 10 percent over the prior year as a result of the costs from higher volumes, patient acuity levels, and rates to serve those volumes. Expenses from labor and supplies grew at a higher rate than volumes due to inflation and productivity deterioration, while the increase in purchased health care services correlated with higher health plan member enrollment. Year-to-date salaries and benefits grew by 7 percent over prior year. This unfavorable trend was driven by full-time equivalent (FTE) growth of 6 percent and rate growth of 3 percent from a competitive labor market.

Supply expense as a percentage of net service revenue is 6 percent higher than the prior year, representing a $299 million increase. This increase was primarily driven by growth of specialty, retail, ambulatory, and infusion center pharmacy costs. Overall supply costs have increased 10 percent over the prior year, primarily driven by pharmacy costs that have increased 14 percent over the same period.

Year-to-date purchased healthcare expenses were 51 percent higher than the prior year as a result of growth in enrolled members of the Providence Health Plan over the prior year.

Non-Operating Income

Non-operating income included a net gain of $5.1 billion in 2016 from the affiliation inherent contribution and one-time debt refinancing, which was primarily driven by the St. Joseph Health affiliation and subsequent debt restructuring. With the impact of the affiliation inherent contribution and debt refinancing removed, year-to-date non-operating gains were $377 million. This amount was driven by year-to-date

investment gains of $493 million in 2016, compared to year-to-date losses of $156 million in 2015. Investment income was partially offset by growth in other non-operating expenses such as pension settlement costs and innovation investments, which were $28 million and $44 million through December, respectively.

Capital and liquidity

Liquidity Indicators	Providence St. Joseph Health (Pro Forma)			
DATA PRESENTED YEAR TO DATE; $ FIGURES PRESENTED IN MILLIONS	12-31-16 ACTUAL	12-31-15 ACTUAL	YTD VAR	YTD VAR %
Accounts Receivable Days	45	46	(1)	(2%)
Days of Cash on Hand	168	177	(9)	(5%)
Long-term Debt to Capitalization	33.9	32.9	1.0	3%
Debt Service Coverage	1.8	3.2	(1.4)	(44%)
Cash to Debt Ratio	148.8	152.7	(3.9)	(3%)
Cash to Total Net Asset Ratio	0.76	0.75	0.01	1%

Unrestricted cash reserves totaled $9.7 billion as of December 31, 2016, up from $9.2 billion as of December 31, 2015. The increase was driven by cash generated from operations, investment gains and proceeds from financing transactions, partially offset by payments related to pension obligations, debt, and capital expenditures. Despite cash growth from prior year, higher costs associated with servicing additional volumes resulted in an overall four day decline in days of cash on hand.

In the third quarter of 2016, the System initiated a series of bond offerings which included the refinancing of certain tax-exempt bonds held by St. Joseph Health prior to the affiliation, executing on a plan to create a single obligated group. The aggregate offering included $448 million of California tax-exempt fixed rate bonds, $286 million of California tax-exempt fixed rate put bonds, $680 million of taxable fixed rate bonds, $100 million of taxable variable rate bonds and a few privately placed direct purchases with staggered tender dates. The offering unified the debt structures of the System at a more favorable cost of capital. While retirement of the existing debt resulted in $60 million in one-time losses on extinguishment of debt, the overall transaction will generate more than $25 million in annual interest savings.

Prior to the debt offering but subsequent to the affiliation of Providence Health & Services and St. Joseph Health, the three national credit rating agencies conducted their annual review process of the newly formed Providence St. Joseph Health. The agencies issued the following credit ratings:

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

All three agencies issued a stable outlook based on the System's favorable enterprise profile and strong financial position. As further evidence of the System's financial strength, the recent bond offering demonstrated ample demand throughout the pricing process from investors.

Subsequent Events

Effective February 23, 2017 the Health System and Catholic Health Initiatives entered into an agreement with Laboratory Corporation of America to sell all of its ownership interest in Pathology Associates Medical Laboratories and its affiliated joint ventures.

In October 2016 Providence St. Joseph Health reached a tentative settlement to resolve an outstanding law suit regarding the Church Plan designation of the Providence Cash Balance Retirement Plan (the Plan). Terms of the settlement included a commitment to contribute $350M over a seven year period and payment of up to $6.5M in plaintiff attorney fees. As a condition of the settlement the Health System will retain the Church Plan designation of the Plan. The settlement is in the process of court approval and class notification. If approved, the settlement will not have a material adverse effect on financial condition of Providence St. Joseph Health.

The System versus St. Joseph Health financial performance crosswalk

As noted previously, the results discussed in this document are presented on a pro forma basis for the System. The tables below represent a comparison of the combined pro forma data for 2016 and 2015 versus audited results of the System, which includes St. Joseph Health financial results from the effective date of the affiliation of July 1, 2016.

Statement of Operations	2016	
DATA PRESENTED YEAR TO DATE; $ FIGURES PRESENTED IN MILLIONS	Providence St. Joseph Health (Pro Forma)	Providence St. Joseph Health Audited Results
Net Patient Revenue	17,296	14,769
Premium and Capitation Revenue	3,773	3,104
Other Revenue	1,088	1,005
Total Revenue	**22,157**	**18,878**
Salaries and Wages	8,926	7,788
Depreciation	1,036	851
Interest and Amortization	265	215
Other Expenses	12,185	10,274
Total Operating Expenses	**22,412**	**19,128**
Excess of Revenues Over Expenses from Operations	**(255)**	**(250)**
Net Nonoperating Gains (Losses)	5,485	5,480
Excess of Revenues Over Expenses	**5,230**	**5,230**

Statement of Operations	2015	
DATA PRESENTED YEAR TO DATE; $ FIGURES PRESENTED IN MILLIONS	Providence St. Joseph Health (Pro Forma)	Providence St. Joseph Health Audited Results
Net Patient Revenue	16,575	11,784
Premium and Capitation Revenue	3,116	1,862
Other Revenue	1,050	788
Total Revenue	**20,741**	**14,434**
Salaries and Wages	8,145	5,984
Depreciation	997	631
Interest and Amortization	260	154
Other Expenses	11,058	7,403
Total Operating Expenses	**20,460**	**14,172**
Excess of Revenues Over Expenses from Operations	**281**	**262**
Net Nonoperating Gains (Losses)	(248)	(185)
Excess of Revenues Over Expenses	**33**	**77**

KPMG

PROVIDENCE ST. JOSEPH HEALTH

Combined Financial Statements

December 31, 2016 and 2015

(With Independent Auditors' Report Thereon)

KPMG LLP
Suite 2900
1918 Eighth Avenue
Seattle, WA 98101

Independent Auditors' Report

The Board of Directors
Providence St. Joseph Health:

We have audited the accompanying combined financial statements of Providence St. Joseph Health, which comprise the combined balance sheets as of December 31, 2016 and 2015, and the related combined statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the combined financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these combined financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of combined financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these combined financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the combined financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the combined financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the combined financial statements, whether due to fraud or error. In making those risk assessments, the auditors consider internal control relevant to the entity's preparation and fair presentation of the combined financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the combined financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the combined financial statements referred to above present fairly, in all material respects, the financial position of Providence St. Joseph Health as of December 31, 2016 and 2015, and the results of its operations and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

KPMG LLP

Seattle, Washington
March 22, 2017

PROVIDENCE ST. JOSEPH HEALTH

Combined Balance Sheets

December 31, 2016 and 2015

(In millions of dollars)

Assets		2016	2015
Current assets:			
Cash and cash equivalents	$	1,000	729
Accounts receivable, less allowance for bad debts of $271 in 2016 and $344 in 2015		2,206	1,570
Supplies inventory		279	195
Other current assets		1,169	540
Current portion of assets whose use is limited		766	256
Total current assets		5,420	3,290
Assets whose use is limited		8,731	5,298
Property, plant, and equipment, net		11,022	6,581
Other assets		1,118	540
Total assets	$	26,291	15,709
Current liabilities:			
Current portion of long-term debt	$	200	245
Master trust debt classified as short-term		153	138
Accounts payable		584	428
Accrued compensation		1,104	641
Other current liabilities		1,911	878
Total current liabilities		3,952	2,330
Long-term debt, net of current portion		6,396	3,696
Pension benefit obligation		1,120	1,064
Other liabilities		1,027	583
Total liabilities		12,495	7,673
Net assets:			
Unrestricted:			
Controlling interest		12,560	7,542
Noncontrolling interest		200	45
Temporarily restricted		816	325
Permanently restricted		220	124
Total net assets		13,796	8,036
Total liabilities and net assets	$	26,291	15,709

See accompanying notes to combined financial statements.

PROVIDENCE ST. JOSEPH HEALTH

Combined Statements of Operations

Years ended December 31, 2016 and 2015

(In millions of dollars)

	2016	2015
Operating revenues:		
Net patient service revenues	$ 14,972	11,969
Provision for bad debts	(203)	(186)
Net patient service revenues less provision for bad debts	14,769	11,783
Premium revenues	2,240	1,464
Capitation revenues	865	399
Other revenues	1,005	788
Total operating revenues	18,879	14,434
Operating expenses:		
Salaries and benefits	9,599	7,341
Supplies	2,788	2,072
Purchased healthcare services	1,917	1,045
Interest, depreciation, and amortization	1,066	785
Purchased services, professional fees, and other	3,758	2,929
Total operating expenses	19,128	14,172
(Deficit) excess of revenues over expenses from operations	(249)	262
Net nonoperating gains (losses):		
Contributions from affiliations	5,167	—
Loss on extinguishment of debt	(60)	—
Investment income (losses), net	403	(114)
Other	(30)	(71)
Total net nonoperating gains (losses)	5,480	(185)
Excess of revenues over expenses	$ 5,231	77

See accompanying notes to combined financial statements.

PROVIDENCE ST. JOSEPH HEALTH

Combined Statements of Changes in Net Assets

Years ended December 31, 2016 and 2015

(In millions of dollars)

	Unrestricted: controlling interest	Unrestricted: noncontrolling interest	Temporarily restricted	Permanently restricted	Total net assets
Balance, December 31, 2014	$ 7,492	45	305	106	7,948
Excess of revenues over expenses	72	5	—	—	77
Contributions, grants, and other	(15)	(5)	89	18	87
Net assets released from restriction	20	—	(69)	—	(49)
Pension related changes	(27)	—	—	—	(27)
Increase in net assets	50	—	20	18	88
Balance, December 31, 2015	7,542	45	325	124	8,036
Excess of revenues over expenses	5,093	138	—	—	5,231
Restricted contributions from affiliations	—	—	405	91	496
Contributions, grants, and other	(13)	17	145	5	154
Net assets released from restriction	19	—	(59)	—	(40)
Pension related changes	(81)	—	—	—	(81)
Increase in net assets	5,018	155	491	96	5,760
Balance, December 31, 2016	$ 12,560	200	816	220	13,796

See accompanying notes to combined financial statements.

PROVIDENCE ST. JOSEPH HEALTH

Combined Statements of Cash Flows

Years ended December 31, 2016 and 2015

(In millions of dollars)

	2016	2015
Cash flows from operating activities:		
Increase in net assets	$ 5,760	88
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Contributions from affiliations	(5,663)	—
Depreciation and amortization	860	631
Provision for bad debt	203	186
Loss on extinguishment of debt	60	—
Restricted contributions and investment income received	(150)	(113)
Net realized and unrealized (gains) losses on investments	(316)	179
Changes in certain current assets and current liabilities	13	(485)
Change in certain long-term assets and liabilities	26	111
Net cash provided by operating activities	793	597
Cash flows from investing activities:		
Property, plant, and equipment additions	(967)	(637)
Sales (purchases) of trading securities, net	68	(242)
Purchases of alternative investments and commingled funds	(466)	(360)
Proceeds from sales of alternative investments and commingled funds	153	44
Cash acquired through affiliations	367	—
Other investing activities	49	(77)
Net cash used in investing activities	(796)	(1,272)
Cash flows from financing activities:		
Proceeds from restricted contributions and restricted income	150	113
Debt borrowings	3,606	453
Debt payments	(3,474)	(400)
Other financing activities	(8)	1
Net cash provided by financing activities	274	167
Increase (decrease) in cash and cash equivalents	271	(508)
Cash and cash equivalents, beginning of year	729	1,237
Cash and cash equivalents, end of year	$ 1,000	729
Supplemental disclosure of cash flow information:		
Cash paid for interest (net of amounts capitalized)	$ 191	142

See accompanying notes to combined financial statements.

(1) Basis of Presentation and Significant Accounting Policies

(a) Reporting Entity

Providence Health & Services (PHS), a Washington nonprofit corporation, is a Catholic healthcare system sponsored by the public juridic person, Providence Ministries.

Effective July 1, 2016, Providence St. Joseph Health (the Health System), a Washington nonprofit corporation, became the sole corporate member of both PHS and St. Joseph Health System (SJHS). SJHS, a California nonprofit public benefit corporation, is a Catholic healthcare system sponsored by the public juridic person, St. Joseph Health Ministry. Due to the circumstances of the business combination between PHS and SJHS, through the alignment under the Health System, the transaction qualified for acquisition accounting with PHS as the acquirer of SJHS.

The Health System seeks to improve the health of the communities it serves, especially the poor and vulnerable. The Health System operations includes 50 hospitals and a comprehensive range of services provided across Alaska, California, Montana, New Mexico, Oregon, Texas, and Washington. The Health System also provides population health management through various affiliated licensed insurers and other risk-bearing entities.

The Health System has filed for an Internal Revenue Service determination letter and believes that it is exempt from federal income tax as a charitable organization under Section 501(c)(3). PHS, SJHS, and substantially all of the various corporations within the Health System have been granted exemptions from federal income tax as charitable organizations under Section 501(c)(3) of the Internal Revenue Code.

The accompanying combined balance sheets and related combined statements of operations, statements of changes in nets assets, and statements of cash flows reflect the PHS financial position and results of operations as of and for the year ended December 31, 2015 and the Health System financial position and results of operations as of and for the year ended December 31, 2016. The Health System results of operations for the year ended December 31, 2016 include twelve months of results of operations for PHS and six months of results of operations for SJHS.

(b) Basis of Presentation

The accompanying combined financial statements of the Health System were prepared in accordance with U.S. generally accepted accounting principles and include the assets, liabilities, revenues, and expenses of all wholly owned affiliates, majority-owned affiliates over which the Health System exercises control, and, when applicable, entities in which the Health System has a controlling financial interest.

Intercompany balances and transactions have been eliminated in combination.

(Continued)

(c) Performance Indicator

The performance indicator is the excess of revenues over expenses. Changes in unrestricted net assets that are excluded from the performance indicator include net assets released from restriction for the purchase of property plant and equipment, certain changes in funded status of pension and other postretirement benefit plans, restricted contributions from affiliations, net changes in noncontrolling interests in combined joint ventures, and certain other activities.

(d) Operating and Nonoperating Activities

The Health System's primary mission is to meet the healthcare needs in its market areas through a broad range of general and specialized healthcare services, including inpatient acute care, outpatient services, physician services, long-term care, population health management, and other healthcare and health insurance services. Activities directly associated with the furtherance of this mission are considered to be operating activities. Other activities that result in gains or losses peripheral to the Health System's primary mission are considered to be nonoperating. Nonoperating activities include investment earnings, gains or losses from debt extinguishment, contributions from affiliations, and certain other activities.

(e) Use of Estimates and Assumptions

The preparation of the combined financial statements in conformity with U.S. generally accepted accounting principles requires the use of estimates and assumptions that affect the reported amounts of assets and liabilities and the reported amounts of revenues and expenses during the reporting periods. Significant estimates and assumptions are used for, but not limited to: (1) allowance for contractual revenue adjustments; (2) allowance for doubtful accounts; (3) fair value of acquired assets and assumed liabilities in business combinations; (4) useful lives of depreciable and amortizable assets; (5) fair value of investments; (6) reserves for self-insured healthcare plans; (7) reserves for professional, workers' compensation and general insurance liability risks; (8) reserves for underwritten prepaid healthcare contracts including managed care contracts and capitation agreements, and (9) contingency and litigation reserves.

The accounting estimates used in the preparation of the combined financial statements will change as new events occur, additional information is obtained or the operating environment changes. Assumptions and the related estimates are updated on an ongoing basis and external experts may be employed to assist in the evaluation, as considered necessary. Actual results could materially differ from those estimates.

(f) Cash and Cash Equivalents

Cash and cash equivalents include highly liquid investments with an original or remaining maturity of three months or less when acquired.

(g) Supplies Inventory

Supplies inventory is stated at the lower of cost (first-in, first-out) or market.

(In millions of dollars)

(h) Property, Plant, and Equipment

Property, plant, and equipment are stated at cost. Improvements and replacements of plant and equipment are capitalized, maintenance and repairs are expensed. The provision for depreciation is determined by the straight-line method, which allocates the cost of tangible property equally over its estimated useful life or lease term. Impairment of property, plant, and equipment is assessed when there is evidence that events or changes in circumstances have made recovery of the net carrying value of assets unlikely.

Interest capitalized on amounts expended during construction is a component of the cost of additions to be allocated to future periods through the provision for depreciation. Capitalization of interest ceases when the addition is substantially complete and ready for its intended use.

Property, plant, and equipment and the total accumulated depreciation at December 31, 2016 and 2015 are shown below:

	Approximate useful life (years)	2016	2015
Land	—	$ 1,419	757
Buildings and improvements	5–60	8,638	5,834
Equipment:			
Fixed	5–25	1,127	1,056
Major movable and minor	3–20	5,466	4,406
Rental property	15–40	941	914
Construction in progress	—	888	275
		18,479	13,242
Less accumulated depreciation		7,457	6,661
Property, plant, and equipment, net		$ 11,022	6,581

Construction in progress primarily represents renewal and replacement of various facilities in the Health System's operating divisions, as well as costs capitalized to software development.

(i) Other Assets

Other assets primarily consist of investments in nonconsolidated joint ventures, beneficial interest in noncontrolled foundations, notes receivable, goodwill, and other intangible assets.

(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.

(Continued)

(In millions of dollars)

The Health System continues to monitor the expected long-term rate of return. If changes in those parameters cause 6.9% 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

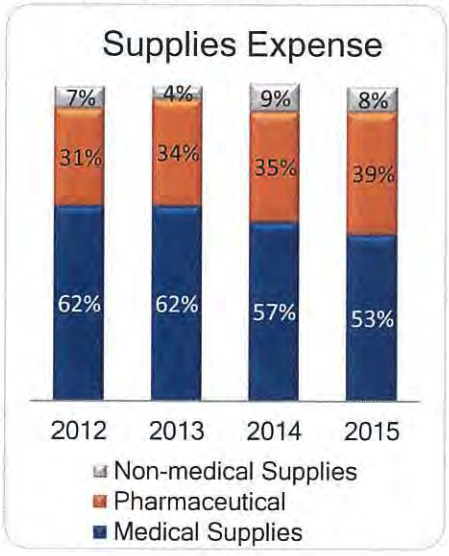
Key Efficiency Indicators *Data is year-to-date*	2015	2014	Organic Growth*
FTEs (presented in thousands)	70.4	65.4	67.1
Productivity - Labor % Net Service Rev.	50.8%	52.0%	50.9%
Supplies % Net Service Revenue	17.6%	17.7%	17.5%
Efficiency - Expense/CMAA	$ 12,040	$ 11,270	$ 12,070

** 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

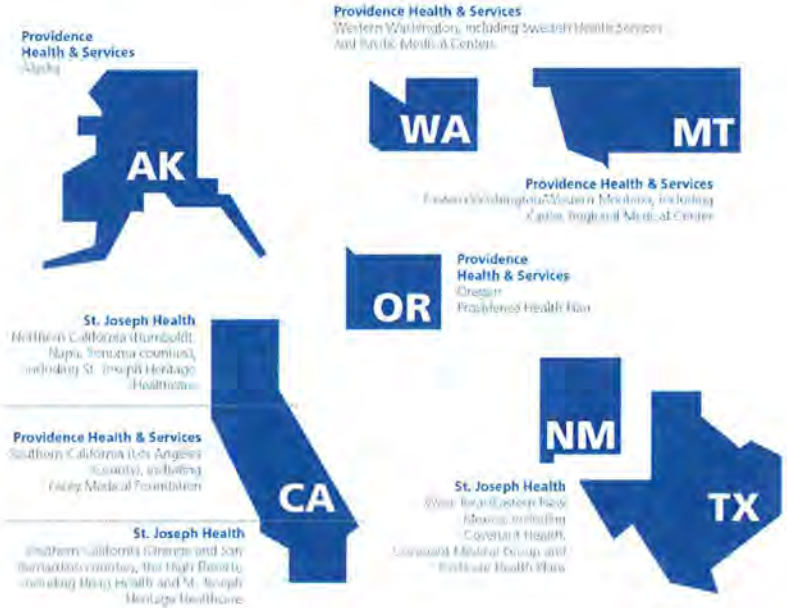
Our Organization

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:

> *"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***

- 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

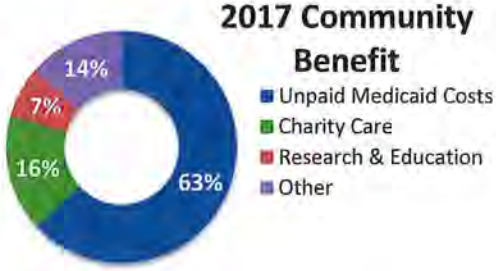
SWEDISH EXPRESS CARE | VIRTUAL PROVIDENCE Express Care at Walgreens PROVIDENCE Express Care at Home circle xealth

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
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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

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.

(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.

(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.