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PO Box 2197
Tacoma, WA 98401-2197

P 253.426.4101
chifranciscan.org

October 21, 2020

RECEIVED
By CERTIFICATE OF NEED PROGRAM at 4:07 pm, Oct 22, 2020

CN21-16

Eric Hernandez, Program Manager
Certificate of Need Program
Department of Health
P.O. Box 47852
Olympia, WA 98504-7852

Dear Mr. Hernandez:

Attached please find CHI Franciscan Highline Medical Center's (St. Anne Hospital) certificate of need application proposing to return the Hospital to its previously licensed bed count by adding 26 medical/surgical beds. The appropriate review and processing fee of $40,470 was received by the Certificate of Need Program on October 20, 2020.

Please do not hesitate to contact me directly with any questions.

Sincerely,

Thomas A. Kruse
Senior Vice President and Chief Strategy Officer

Certificate of Need Application
Hospital Projects

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

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

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

<table>
<tr><td>Signature and Title of Responsible Officer

Senior Vice President and Chief Strategy Officer

Email Address:
thomaskruse@chifranciscan.org</td><td>Date: October 21, 2020

Telephone Number: 253-680-4003</td></tr>
<tr><td>Legal Name of Applicant

CHI Franciscan/Highline Medical Center (St. Anne Hospital)

Address of Applicant

16251 Sylvester Road SW
Burien, WA 98166</td><td>☐New hospital
☒Expansion of existing hospital (identify facility name and license number)

Provide a brief project description, including the number of beds and the location.

Return to previously licensed bed count, by adding 26 medical/surgical beds

Estimated capital expenditure: $0</td></tr>
<tr><td colspan="2">Identify the Hospital Planning Area

Southwest King Hospital Planning Area</td></tr>
<tr><td colspan="2">Identify if this project proposes the addition or expansion of one of the following services:
☐NICU Level II ☐ NICU Level III ☐ NICU Level IV ☐ Specialized Pediatric (PICU) ☐ Psychiatric (within acute care hospital)
☐ Organ Transplant (identify) ☐ Open Heart Surgery ☐ Elective PCI ☐ PPS-Exempt Rehab (indicate level) ☐ Specialty Burn Services</td></tr>
</table>

St. Anne Hospital

CERTIFICATE OF NEED APPLICATION PROPOSING TO RESTORE PREVIOUSLY LICENSED BED COUNT BY ADDING 26 ACUTE CARE BEDS IN THE SOUTHWEST KING HOSPITAL PLANNING AREA

October 2020

SECTION 1
Applicant Description

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

The legal name of the applicant is CHI Franciscan Highline Medical Center (Highline). Highline is a Washington not-for-profit corporation. On June 2, 2020, Highline began doing business as St. Anne Hospital. However, Highline Medical Center is still the correct legal entity. For the ease of this application, the hospital will be referred to as St. Anne.

CHI Franciscan Health System (CHI Franciscan) is the sole corporate member of Highline. CHI Franciscan is part of Common Spirit Health, the new entity formed following the merger of Catholic Health Initiatives and Dignity Health in February of 2019. Common Spirit Health does not have direct ownership or management of any facilities in Washington State.

The address of St. Anne Hospital is:

16251 Sylvester Road SW
Burien, WA 98166

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

As noted above, on June 2, 2020, Highline began started doing business as St. Anne Hospital. Highline is a Washington nonprofit corporation. Highline's UBI number is 600 305 640.

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

Questions regarding this application should be sent to:

Thomas A. Kruse
Senior Vice President and Chief Strategy Officer
CHI Franciscan
1145 Broadway Plaza | Suite 1200 | Tacoma, WA 98402
253.680.4007
thomaskruse@chifranciscan.org

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

The consultant authorized to speak on behalf of the screening related to this application is:

Jody Carona
Health Facilities Planning & Development
120 1st Avenue West, Suite 100
Seattle, WA 98119
(206) 441-0971
(206) 441-4823 (fax)
Email: healthfac@healthfacilitiesplanning.com

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

The requested organizational chart is included in Exhibit 1.

Section 2
Facility Description

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

The name and address of the applicant is St. Anne Hospital, located at:

16251 Sylvester Road SW
Burien, WA 98166

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

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

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

St. Anne's existing identification numbers are as follows:

HAC.FS: 00000126

Medicare #:500011

Medicaid #:3319506

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

St. Anne is currently accredited by the Joint Commission. St. Anne's current accreditation expires in September 2022.

5. **Is the facility operated under a management agreement?**
   Yes ____ No ___X___

   If yes, provide a copy of the management agreement.

This question is not applicable.

6. **Provide the following scope of service information:**

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

Table 1
St. Anne Hospital Scope of Services

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

Source: Applicant

Section 3
Project Description

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

Highline operated as a 159-bed hospital (154 acute med/surg and 5 Level II nursery) until Regional Hospital for Respiratory and Complex Care (Regional) relocated to its 5th floor Cedar Unit and occupied a 26-bed unit in 2014. Prior to relocating, Regional filed a CN application to relocate 40 beds, in two phases, from the Riverton Campus of Highline to the Burien campus. The Regional beds were to be relocated in two phases, with Phase 1, being 26 beds that were to be housed in newer, private rooms located on the 5th floor of Highline's Burien campus. Almost simultaneously, St. Anne also applied seeking CN approval to build a new tower on its Burien campus. Among other services, the new Tower would have allowed for Phase 2 of the Regional project to be undertaken (14 beds) and it would have allowed Highline to recapture the 26 beds that were being lost due to Regional relocation. That CN was approved and was issued on October 27, 2014. A condition placed on the CN required that the patient tower project be commenced by October 2016. Because that did not happen, Highline relinquished the CN.

Since that time, and in response to changing eligibility criteria and reimbursement, CHI Franciscan, the owners of Regional Hospital elected to cease operations of that hospital. The hospital ceased operation in January of 2020. St. Anne has begun re-using the 5th floor space (and timely notified Licensing that we did) but removed beds from elsewhere in the hospital so as not to exceed 128 licensed medical/surgical beds.

This CN application simply seeks to have the 26 beds returned to the license. The project can be completed within days of CN approval. There is no capital expenditure.

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

This project does not propose the expansion of a tertiary service.

3. **Provide a breakdown of the beds, by type, before and after the project. If the project will be phased, include columns detailing each phase.**

Table 2 details St. Anne's current and proposed bed configuration.

Table 2
St. Anne Hospital
Current and Proposed Bed Configuration

	Current	Proposed
General Acute Care	128	154
PPS Exempt Psych	0	0
PPS Exempt Rehab	0	0
NICU Level II	5	5
NICU Level III	0	0
NICU Level IV	0	0
Specialized Pediatric	0	0
Skilled Nursing	0	0
Swing Beds (included in General Acute Care)	0	0
Total	**133**	**159**

Source: Applicant

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

Approximately five to ten of the licensed acute care beds listed in Table 2 are not currently set up because St. Anne has converted a number of semi-private rooms to private to support COVID care. Please note that the number can and does swing based on census and clinical need.

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

Table 3 provides the anticipated timeline for this project.

Table 3
St. Anne Hospital
Proposed Timeline for 26 Bed Addition

Event	Anticipated Month/Year
Anticipated CN Approval	April 2021
Design Complete	N/A
Construction Commenced	N/A
Construction Completed	N/A
Facility Prepared for Survey	NA
Facility Licensed – Project Complete WAC 246-310-010(47)	April 2021

Source: Applicant

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

The new beds will be general medical/surgical beds and provide care primarily to adults. The most common conditions treated at St. Anne include general medical, pulmonary conditions, septicemia, OB, orthopedics, medical and interventional cardiology (including emergency PCI), general surgery, neurology, gastroenterology, and oncology.

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

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

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

The requested drawings for the 26-bed addition, located on 5 Cedar, is included in Exhibit 3.

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

The gross square footage of St. Anne's, with and without the project, is 265,092.
The gross square footage for the 26-bed unit is 20,281.

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

This project does not require any construction. This question is not applicable.

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

    The Certificate of Need program highly recommends that applicants consult with the office of Construction Review Services (CRS) early in the planning process. CRS review is required prior to construction and licensure (WAC 246-320-500 through WAC 246-320-600). Consultation with CRS can help an applicant reliably predict the scope of work required for licensure and certification. Knowing the required construction standards can help the applicant to more accurately estimate the capital expenditure associated with a project. Note that WAC 246-320-505(2)(a) requires that hospital applicants request and attend a presubmission conference for any construction projects in excess of $250,000.

This project has met all Construction Review requirements. Therefore, this question is not applicable.

Section 4
Need (WAC 246-310-210)

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

St. Anne is located in the Southwest King Hospital Planning Area (Southwest King). There are no other hospitals located in this Planning Area.

2. **For projects proposing to add acute care beds, provide a numeric need methodology that demonstrates need in this planning area. The numeric need methodology steps can be found in the Washington State Health Plan (sunset in 1989).**

On October 6, 2020, CHI Franciscan representatives conferenced with CN Program staff to make them aware of a number of problems inherent in the Department of Health's (Department) 2019 CHARS database. Per an October 6 email from the Department, even though data submitted to the Department by the State's hospitals is correctly loaded into the CHARS system, the extraction method has been impacted by the update of a 3M grouper. Our analysis suggests that a similar issue occurred sometime beginning in the second half of 2018 as well. The Department has committed to correcting the errors, but does not have an estimated completion date.

In our conversation with the CN Program, there was consensus that due to the errors in the 2019 data, CHI Franciscan should run the methodology using 2018 as the baseline. Because, in the case of St. Anne CHARS 2018 also appears to have errors and is approximately 10% lower than actual internal data, we ran two methodologies, one using CHARS 2018 as the baseline and a version with St. Anne's actual 2018. In the case of the Southwest King Hospital Planning Area, St. Anne is the sole hospital, making the adjustment very reasonable.

The version of the methodology using 2018 CHARS is included as Exhibit 4. This demonstrates a need for all 26 beds in 2027; or two years beyond the typical seven-year planning horizon. Exhibit 4 includes a version in which we used actual St. Anne data for 2018. This methodology is included in Exhibit 4 and demonstrates the need for all 26 beds in 2024. Given that actual data from St. Anne demonstrates there were likely upload errors in late 2018, use of St. Anne's actual data provides for a more accurate projection.

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

St. Anne proposes to add back the 26 beds lost due to Regional relocation. 100% of these beds will be general medical/surgical beds.

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

Table 4 details patient days for the past three full calendar years for the type of beds (medical/surgical) that will increase with the project. Table 5 details the same information for the entire hospital.

Table 4
St. Anne Medical/Surgical Patient Days and Discharges, 2017-2019
Excludes all Newborns

Project-Specific Only	**2017**	**2018**	**2019**
Licensed beds	112	112	112
Available beds	112	112	112
Discharges	6,078	5,531	5,617
Patient days	29,106	28,047	29,698

Source: Applicant, 2017 discharges and days from CHARS, excludes newborns

Table 5
St. Anne Hospital Total Patient Days and Discharges, 2017-2019,
Excludes all Newborns

Entire Hospital	**2017**	**2018**	**2019**
Licensed beds	128	128	128
Available beds	128	128	128
Discharges	7,111	6,460	6,647
Patient days	31,109	29,750	31721

Source: Applicant, 2017 discharges and days from CHARS, excludes all newborns and 5 Level II bassinets

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

Table 6 includes the requested seven-year estimate of medical/surgical patient days. Table 7 provides the same information for all acute care beds, less the Level II Neonatal unit.

Table 6
St. Anne Medical/Surgical Patient Days and Discharges, 2020-2025
Excludes all Newborns

Project-Specific Only	2020	2021	2022	2023	2024	2025
Licensed beds	112	138	138	138	138	138
Available beds	112	138	138	138	138	138
Discharges	5,667	5,837	6,071	6,314	6,535	6,731
Patient days	29,961	30,860	32,095	33,379	34,547	35,583

Source: Applicant

Table 7
St. Anne Hospital Total Patient Days and Discharges, 2017-2019,
Excludes all Newborns

Entire Hospital	2020	2021	2022	2023	2024	2025
Licensed beds	128	154	154	154	154	154
Available beds	128	154	154	154	154	154
Discharges	6,708	6,909	7,185	7,473	7,734	7,966
Patient days	32,010	32,970	34,289	35,661	36,909	38,016

Source: Applicant

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

The requested information is included in Exhibit 6.

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

St. Anne is the only hospital located in Southwest King Hospital; the *State Health Plan's* adjusted target occupancy for a hospital the be size of St. Anne is 65%. While St. Anne averages about 70% average midnight occupancy, internal data shows that mid-day/mid- week (between 10AM and 1 PM), census is typically 10-20% higher, meaning that there are significant days and times of day when there are no beds are available, and patients are held in ED or diverted.

As depicted in Table 8, in 2018, the 112 medical surgical beds operated at 69% and 73% midnight occupancy, respectfully. About 5% of the time, in both years, the medical surgical beds were at 95% occupancy at midnight. Nine percent of the time in 2018 and nearly 12% of the time in 2019 it was above 85%.

Table 8
St. Anne Hospital
2018 and 2019 ADC and Occupancy

	2018		**2019**	
	Total Med/Surg	**Total**	**Total Med/Surg**	**Total**
Current Licensed/ Set-Up Beds	112	128	112	128
Avg. Daily Census (ADC) at Midnight	76.8	81.6	81.4	86.9
Target Avg. Occupancy	65%	65%	65%	65%
Actual Avg. Occupancy	68.6%	63.8%	72.6%	67.9%
Occupancy				
100%	1	0	2	0
95%	4	0	3	1
90%	18	3	19	4
85%	33	14	42	14
80%	63	27	91	34
75%	107	56	143	82
70%	147	96	221	150
Target Occupancy per SHP: 65%	207	150	291	233
60%	273	216	333	304

Source: Applicant

The Governor's Proclamation #20-24.1 dated May 18, 2020, limited inpatient census to 80% of available (defined as licensed and staffed beds) capacity. The intent was to assure surge capacity. This proclamation, while reflective of the current Public Health Emergency, does impact access. Table 9 shows that if the Proclamation had been in effect in 2019, St. Anne would have only been able to have 102 beds in use, and would have exceeded "capacity" more than 36 times at midnight, and many more times during the day, causing significant diversion of patients.

Table 9
St. Anne Hospital
2018 and 2019 ADC and Occupancy

	2019
Licensed Beds Assuming 80% of Med/Surg (128 licensed beds)	102
Avg. Daily Census (ADC) at Midnight	86.9
Target Avg. Occupancy	65.0%
Actual Avg. Occupancy (102 beds)	85.0%
Occupancy	
100%	36
95%	72
90%	125
85%	190
80%	250
75%	307
70%	337
Target Occupancy per SHP: 65%	361
60%	364

Source: Applicant

There are a number of factors in the geography and socioeconomics of the communities served by St. Anne that make access more challenging than in most other communities. These challenges are compounded by the public health emergency and King County's declared civil emergency, demonstrating that these communities are no longer assured accessible health care.

The closure of the High-Rise West Seattle Bridge (the civil emergency) has also impacted access, as West Seattle is part of the Southwest King Hospital Planning Area. The bridge closed on March 23, 2020 because of severe cracking on its underside and concerns regarding collapse. The expected "fix" is years out. Data collected by St. Anne shows that since April, ambulance runs from West Seattle to St. Anne are consistently up about 10%. Further while total ED visits

are down throughout the region, the percentage of patients in the ED being admitted to the Hospital has increased from about 13% to 15%, an increase of 17%.

The communities served by St. Anne are among the most diverse and underserved in the state, and the socioeconomics of South King County have been extensively vetted by King Public Health and other organizations, including Washington's Department of Health. For example, Public Health-Seattle & King County, Evergreen Health, CHI Franciscan Health (St. Elizabeth Hospital, St. Francis Hospital, and Highline), Kaiser Permanente, MultiCare Health System (Auburn Medical Center and Covington Medical Center), Navos, Overlake Medical Center, Seattle Cancer Care Alliance, Seattle Children's, Swedish Medical Center (Ballard Campus, Cherry Hill Campus, First Hill Campus, Issaquah Campus), UW Medicine (Harborview Medical Center, Northwest Hospital & Medical Center, UW Medical Center and Valley Medical Center), Virginia Mason and the Washington State Hospital Association collectively produced *the King County Community Health Needs Assessment 2018/2019*. That Report found:

> *"People of color and low-income residents are at disproportionate risk of being uninsured and having poor health and social outcomes. Many health and social indicators—such as housing quality, alcohol related deaths, obesity, lack of health insurance, and smoking—show regional patterns of inequity.* ***South King County is home to some of the most racially and ethnically diverse communities in our county, and experiences disparities in multiple health and social indicators.***

In addition, and as can be identified in the map on the next page, a report by the Northwest Healthcare Response Network and King County Health Department found that COVID-19 disproportionally affects socioeconomically disadvantaged populations. This report identified South King County as both a hot spot in terms of socioeconomic disadvantage status and in terms of positive COVID-19 tests.

Because our COVID census has been high and has remained high, St. Anne put into place a dedicated team and has established a "center of excellence" for COVID with reverse air flow in the patient rooms. Today, as of the submittal of this application, St. Anne has 16 COVID patients in-house. These admissions are unscheduled and moving the patient quickly to the dedicated unit, in a private bed, is a best practice, making bed availability paramount.

Socioeconomic Disadvantage Index in King County

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

Admission to each of CHI Franciscan's facilities and programs is based on clinical need. Services are made available to all persons regardless of race, color, creed, sex, national origin, or disability. A copy of CHI Franciscan's admission and non-discrimination policy is included as Exhibit 7.

For hospital charity care reporting purposes, the Department divides Washington State into five regions. St. Anne is located in the King County Region. According to 2016-2018 charity care data produced by the Department (the latest data available), the three-year charity care average for the Region, excluding Harborview, was 1.00% of gross revenue and 2.11% of adjusted revenue. During the same time frame, St. Anne's charity care was 1.39% and 4.49%, respectively. The percentage of charity care included in the pro forma is 1.6% of total revenue, which is based on 2019.

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

This question is not applicable.

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

This question is not applicable.

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

The requested policies are included in Exhibit 7. Please note that CHI Franciscan is in the process of updating its charity care policy and a new policy is expected by early 2021. In the meantime, the current posted policy (and the one included in Exhibit 7) is the current policy.

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

1. **Provide documentation that demonstrates the immediate and long-range capital and operating costs of the project can be met. This should include but is not limited to:**
   - **Utilization projections. These should be consistent with the projections provided under the Need section. Include all assumptions.**
   - **A current balance sheet at the facility level.**
   - **Pro forma balance sheets at the facility level throughout the projection period.**
   - **Pro forma revenue and expense projections for at least the first three full calendar years following completion of the project. Include all assumptions.**
   - **For existing facilities, provide historical revenue and expense statements, including the current year. Ensure these are in the same format as the pro forma projections. For incomplete years, identify whether the data is annualized.**

Each requested data item is included in Exhibit 5.

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

St. Anne's fiscal year is June 30.

3. **Provide the following agreements/contracts:**
   - **Management agreement**
   - **Operating agreement**
   - **Development agreement**
   - **Joint Venture agreement**

St. Anne does not have any of the above agreements or contracts. Therefore, this question is not applicable.

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

The site is owned by CHI Franciscan. Included in Exhibit 8 is documentation from the King County Assessor's office documenting that CHI Franciscan owns the site on which the hospital is located.

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

Included in Exhibit 8 is documentation from the King County Assessor's office documenting that CHI Franciscan owns the site on which the hospital is located and that its present use is a hospital.

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

There are no capital expenditures proposed for this project. This question is not applicable.

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

As discussed in response to earlier questions. There are no capital expenditures proposed for this project, and as such, this question is not applicable.

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

St. Anne's is an existing operation. No start-up period is anticipated.

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

As discussed in response to the previous question, there is no start up period. This question is not applicable.

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

There is no construction proposed for this project. Therefore, this question is not applicable.

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

There are no capital costs, construction or otherwise proposed for this project. As such, there is no impact on the costs or charges for health services because of this project.

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

St. Anne's payer mix is not proposed to change as a result of the bed addition. Table 10 details the current and proposed payer mix.

Table 10
St. Anne Hospital
Current and Proposed Payer Mix

Payer Mix	Percentage by Revenue	Percentage by Patient
Medicare	43.4%	37.6%
Medicaid	23.7%	24.7%
Commercial	0.9%	1.0%
Managed Care	26.4%	30.4%
Other Government (L&I, VA, etc.)	1.0%	0.7%
Workers Comp	0.8%	1.2%
Self-Pay	3.4%	3.9%
Other	0.4%	0.5%
Total	**100.0%**	**100.0%**

Source: Applicant

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

This information was provided in response to Question #12.

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

This project does not propose any new equipment.

15. **Identify the source(s) of financing and start-up costs (loan, grant, gifts, etc.) and provide supporting documentation from the source. Examples of supporting documentation include: a letter from the applicant's CFO committing to pay for the project or draft terms from a financial institution.**

    If this project will be debt financed through a financial institution, provide a repayment schedule showing interest and principal amount for each year over which the debt will be amortized.

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

16. **Provide the most recent audited financial statements for:**
    - **The applicant, and**
    - **Any parent entity.**

The requested information is included in Appendix 1.

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

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

The requested information on other facilities owned/operated and or affiliated with CHI Franciscan is included in Exhibit 9.

2. **Provide a table that shows full time equivalents (FTEs) by type (e.g. physicians, management, technicians, RNs, nursing assistants, etc.) for the facility. If the facility is currently in operation, include at least the most recent full year of operation, the current year, and projections through the first three full years of operation following project completion. There should be no gaps. All FTE types should be defined.**

The requested information is included in Exhibit 5.

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

Salary expense corresponds to the FTEs needed to provide the service. FTEs increase in accordance with the increase in patient days. The projected FTEs do not include any compensation increases.

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

The key clinical staff are as follows:

Table 11
St. Anne Hospital Key Staff

Name	Title	Professional License Number
Aparna Ananth, MD	Market VP Medical Operations	MD00045928
Toni Black, RN	Director, Nursing Operations	RN60094927
Mike Anderson, MD	Chief Medical Officer	MD00037873
Patti Ellisor, RN	Chief Nursing Officer	RN60658675

Source: Applicant

5. **Describe your methods for staff recruitment and retention. If any barriers to staff recruitment exist in the planning area, provide a detailed description of your plan to staff this project.**

For an organization the size of CHI Franciscan, and because this project proposes an expansion of an existing facility, the staffing needs noted in Table 11 are relatively small and due only to normal growth associated with the State's Acute Care Bed Need Methodology In an effort to assure that we always have the staff needed to support our existing and proposed new programs, CHI Franciscan offers a competitive wage and benefit package as well as numerous other recruitment and retention strategies. Specific strategies for clinical, ancillary and support staff include:

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

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

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

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

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

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

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

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

Based on the above, St. Anne's has demonstrated that it has the necessary infrastructure in place to recruit the additional staff needed for this project.

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

St. Anne's is not a new facility. This question is not applicable.

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

The existing ancillary and support services, and an indication as to whether they are provided in house or under agreement, are provided in Table 12:

Table 12
Ancillary and Support Services

Services Provided	Vendor
Linen service	In-house
Pathology	Cellnetix
Janitorial services	In-house
Biomedical	In-house
Biomedical waste	Stericycle
PT (PRN)	PRN Physical Rehab Network
Dietary	Thomas Cuisine
Respiratory Therapy	In-house

Source: Applicant

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

No existing ancillary or support agreements are expected to change as a result of this project.

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

St. Anne works closely with most healthcare providers in Southwest King County, as well as those in downtown Seattle, South King County and Pierce County. This includes EMS, primary care and specialty clinics, other hospitals, nursing homes, assisted living communities, home health and hospice.

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

No existing working relationships are expected to change as a result of this project.

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

This question is not applicable.

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

The additional acute care beds will promote continuity of care particularly considering the access issues outlined in the *Need* section. St. Anne's already high occupancy has been compounded by the Governor's capacity proclamation, the community's health disparities and socioeconomic challenges, and King County's civil emergency resulting from the West Seattle bridge closure. An adequate number of medical/surgical beds must be located close to where patients reside. Approval of the project will promote timely access to inpatient service by enhancing St. Anne's bed capacity.

13. **Provide an explanation of how the proposed project will have an appropriate relationship to the service area's existing health care system as required in WAC 246-310-230(4).**

As noted above, St. Anne has a long track record of working closely with EMS, other existing hospitals, and other health care systems throughout the Puget Sound Region. St. Anne's collaborates with area nursing homes, assisted living, adult family homes, home health, and hospice agencies as well as outpatient providers. St. Anne also supports area primary care and specialists, as well as insurers to assure care coordination, smooth transitions of care, and reduced rehospitalization and ED visits.

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

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

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

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

St. Anne's plan has always been to restore the beds lost when Regional Hospital relocated to our 5th floor Cedar unit, particularly since the beds leased to Regional were all private rooms (approximately one-third of St. Anne's beds are located in semiprivate rooms). The original project to restore the licensed bed count was part of a proposed $53 million, 62,000 square foot addition to the Hospital. While the original project is still needed, especially the outpatient square footage and the resultant increase in private rooms, the January 2020 vacation of 5 Cedar by Regional provided an inexpensive and quick means of addressing high occupancy. It also provided increased private room capacity to treat a potential COVID-19 surge; it did however require that beds be taken off-line elsewhere in the hospital to not exceed 128 medical/surgical beds.

As such, the only other option considered was whether all 26 beds should be brought online at the same time or divided into two phases. Because the 26-bed unit is 100% private rooms and already equipped, the decision was made to return to 154 acute care beds immediately upon CN approval. This also provides relief to the sole hospital servicing the Southwest King Hospital Planning Area, should COVID-19 continue into 2021 and beyond, and should the West Seattle Bridge closure involve multiple years of diverted traffic.

2. Provide a comparison of this project with alternatives rejected by the applicant. Include the rationale for considering this project to be superior to the rejected alternatives. Factors to consider can include, but are not limited to patient access to healthcare services, capital cost, legal restrictions, staffing impacts, quality of care, and cost or operation efficiency.

Table 13 details the requested information.

Table 13
Advantages and Disadvantages

	Add 26 acute care beds (the project)	Add 26 beds in Two Phases	No Action
Patient Access to Health Care Services	Provides relief to high census and more private room bed capacity. Reduces barriers to access for our community.	Provides relief to high census and more private room bed capacity. Reduces barriers to access for our community. Phasing the beds results in an unnecessary and artificial barrier during times of peak census and during the day (mid-day/mid-week).	St. Anne would continue to face occupancy pressures and patient access is compromised.
Capital Costs	No capital required	No capital required	Not applicable
Staffing Impact	The additional beds allow St. Anne to increase census, requiring a relatively small number of additional staff due	The additional beds allow St. Anne to increase census, requiring a relatively small number of additional staff due. Phasing could allow the staff increases to occur over more years but would be at the expense of access.	Not applicable
Quality of Care	Increase in private rooms supports best practice.	Increase in private rooms supports best practice	Not applicable
Cost or Operational Efficiency	Cost per patient day decreases due to increased census	Cost per patient day decreases due to increased census	No opportunity to improve operational efficiency
Legal	None	None	Not applicable

Source: Applicant

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

This project does not involve any construction. This question is not applicable.

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

As discussed in earlier sections of this application, St. Anne is able to add these beds to the hospital without any capital expenditure, and given the pressures our occupancy, this is both prudent and necessary to assure access. St. Anne will, with the additional beds, increase its overall operating efficiency as measured by average cost per patient day. The average cost decreases by about 10% over the project timeline.

Exhibit 1
Organizational Chart

COMMONSPIRIT HEALTH ORGANIZATION CHART
(INCLUDES JOINT VENTURES)

Revised July 24, 2020

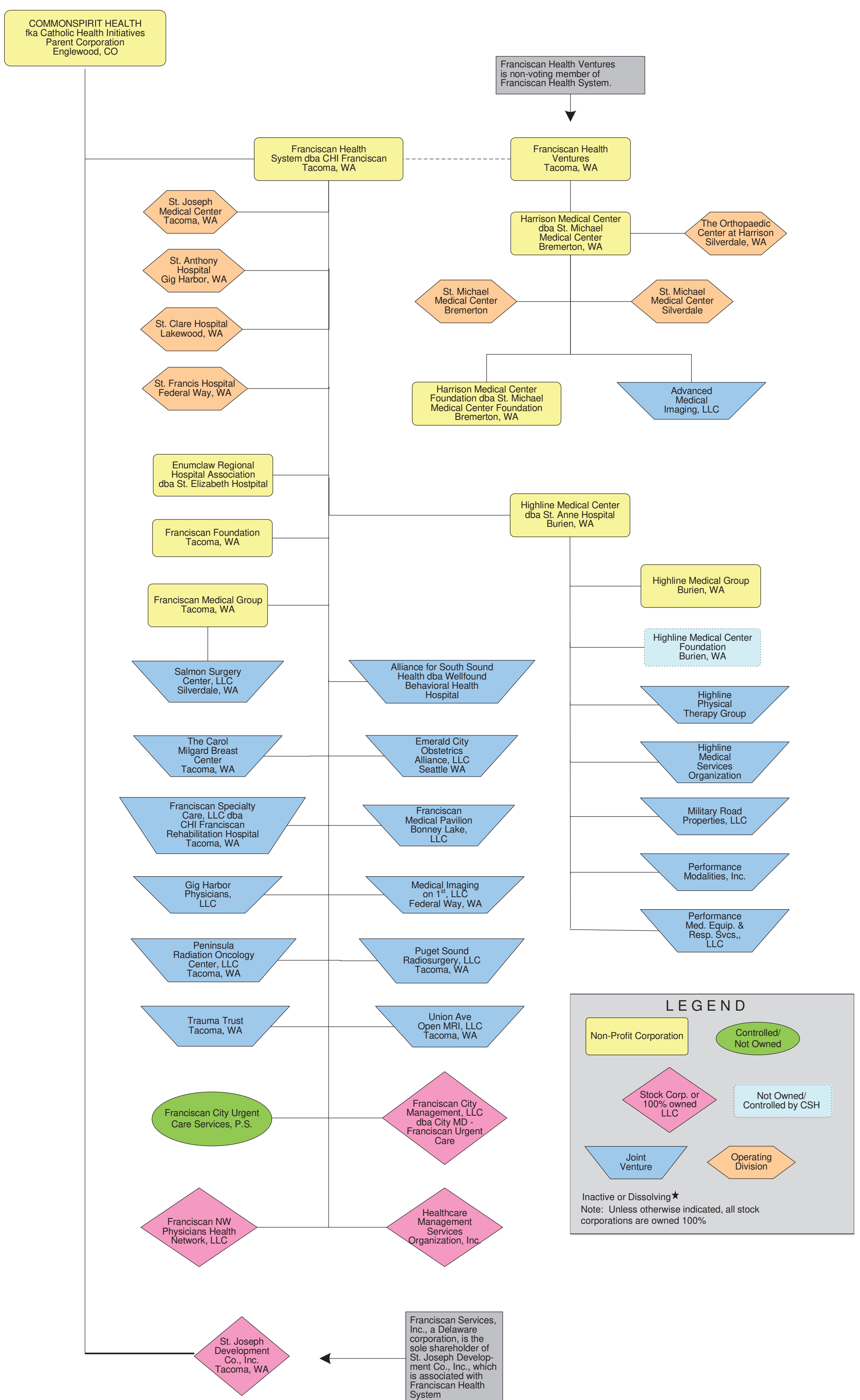


Exhibit 2
LOI

Highline Medical Center
16251 Sylvester Road SW
Burien, WA 98166

P 206.244.9970
highlinemedicalcenter.org

RECEIVED
By Certificate of Need Program at 3:08 pm, Apr 22, 2020

April 20, 2020

Nancy Tyson, Executive Director
Certificate of Need Program
Department of Health
PO Box 47852
Olympia, WA 98504-7852

Dear Ms. Tyson:

In accordance with WAC 246-310-080, CHI Franciscan here within submits a letter of intent to add 26 beds to Highline Medical Center's licensed bed capacity.

In conformance with WAC, the following information is provided:

1. **A Description of the Extent of Services Proposed:**
Highline Medical Center is currently licensed for 133 beds (5 Level II neonatal and 128 acute care beds). Highline proposes to return to its previously licensed 159 beds, by adding 26 new acute care beds in existing space.

2. **Estimated Cost of the Proposed Project:**
The expenditure associated with the replacement project is $0.

3. **Description of the Service Area:**
Highline is located within, and the majority of its patients reside within, the Southwest King Hospital Planning Area.

Thank you for your interest in this matter.

Sincerely,

Russell J. Woolley
Chief Operating Officer

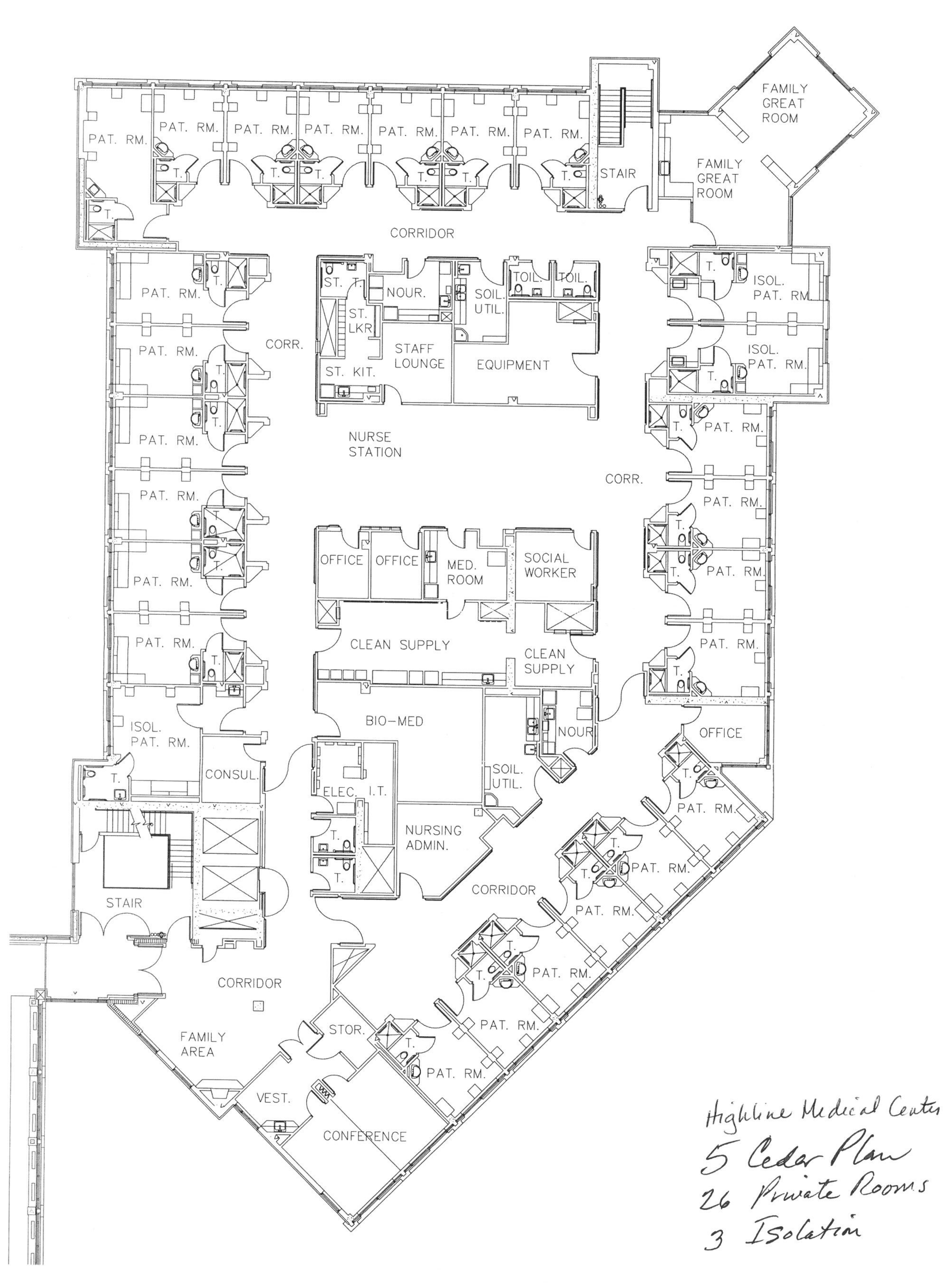
St. Anthony Hospital – Gig Harbor
St. Clare Hospital – Lakewood
St. Elizabeth Hospital – Enumclaw
St. Francis Hospital – Federal Way
St. Joseph Medical Center – Tacoma

Harrison Medical Center
Bremerton + Silverdale
Highline Medical Center – Burien
Regional Hospital – Burien

Franciscan Medical Group
Harrison HealthPartners

Foundations:
Franciscan Foundation
Harrison Medical Center Foundation
Highline Medical Center Foundation

Exhibit 3
Drawing of 26 Bed Unit



Highline Medical Center
5 Cedar Plan
26 Private Rooms
3 Isolation

Exhibit 4
Acute Bed Methodology

Acute Bed Methodology
from Internal Data

Step 1

1. 2009-2018 Total Resident Days

Excludes MDC 19 and MDC 15, Rehab Service Line

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Southwest King	78,913	77,469	81,073	77,944	82,129	86,021	86,432	87,460	87,834	85,875
HSA# 1	1,273,445	1,267,477	1,295,218	1,277,547	1,299,353	1,339,232	1,406,024	1,432,166	1,474,392	1,504,972
Statewide Total	2,058,647	2,044,196	2,058,891	2,045,627	2,060,462	2,109,252	2,206,003	2,256,175	2,323,198	2,363,159

STEP 2: Total Resident Days Adjusted to Exclude All Psychiatric Patient Days

2-A. 2009-2018 Total Resident Days (from Step 1)
Excludes MDC 19, MDC 15, Rehab

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Southwest King	78,913	77,469	81,073	77,944	82,129	86,021	86,432	87,460	87,834	85,875
HSA# 1	1,273,445	1,267,477	1,295,218	1,277,547	1,299,353	1,339,232	1,406,024	1,432,166	1,474,392	1,504,972
Statewide Total	2,058,647	2,044,196	2,058,891	2,045,627	2,060,462	2,109,252	2,206,003	2,256,175	2,323,198	2,363,159

2-B. 2009-2018 Total Psychiatric Hospital Non-MDC 19 Patient Days
Excludes MDC 19, MDC 15, Rehab

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Southwest King	62	66	62	121	429	1154	1858	1882	2155	2,009
HSA# 1	1816	1384	1639	2907	3101	9823	16266	15326	16222	16,235
Statewide Total	2119	1563	1916	3185	3410	11148	18411	18138	19685	20467

NOTE: Relevant to this Step, there are 4 psychiatric hospitals statewide:

Fairfax Hospital, Kirkland: ***Located in HSA 1 and East King Planning Area***
Navos, Seattle: ***Located in HSA 1 and Southwest King Planning Area***
Lourdes Counseling Center, Richland: ***Located in HSA 3 and Benton-Franklin Planning Area***

2C. 2009-2018 Total Resident Days Adjusted to Exclude All Psychiatric Patient Days
Excludes MDC 19, MDC 15, Rehab

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Southwest King	78,851	77,403	81,011	77,823	81,700	84,867	84,574	85,578	85,679	83,866
HSA# 1	1,271,629	1,266,093	1,293,579	1,274,640	1,296,252	1,329,409	1,389,758	1,416,840	1,458,170	1,488,737
Statewide Total	2,056,528	2,042,633	2,056,975	2,042,442	2,057,052	2,098,104	2,187,592	2,238,037	2,303,513	2,342,692

STEP 3: **Historical Average Use Rates**

3-A. 2009-2018 Total Resident Days Adjusted to Exclude All Psychiatric Patient Days (from Step 2-C.)

Excludes MDC 19, MDC 15, Rehab, Mary Bridge

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Southwest King	78,851	77,403	81,011	77,823	81,700	84,867	84,574	85,578	85,679	83,866
HSA# 1	1,271,629	1,266,093	1,293,579	1,274,640	1,296,252	1,329,409	1,389,758	1,416,840	1,458,170	1,488,737
Statewide Total	2,056,528	2,042,633	2,056,975	2,042,442	2,057,052	2,098,104	2,187,592	2,238,037	2,303,513	2,342,692

3-B. 2009-2018 Total Populations

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Southwest King	237,881	239,050	242,228	245,487	248,830	252,261	255,785	259,406	263,128	266,448
HSA # 1	4,174,871	4,204,534	4,231,500	4,261,500	4,303,625	4,361,850	4,429,440	4,523,580	4,612,100	4,659,617
Statewide Total	6,672,159	6,724,540	6,767,900	6,817,770	6,882,400	6,968,170	7,061,410	7,183,700	7,310,300	7,396,097

3-C. 2009-2018 Total Use Rates Per 1,000

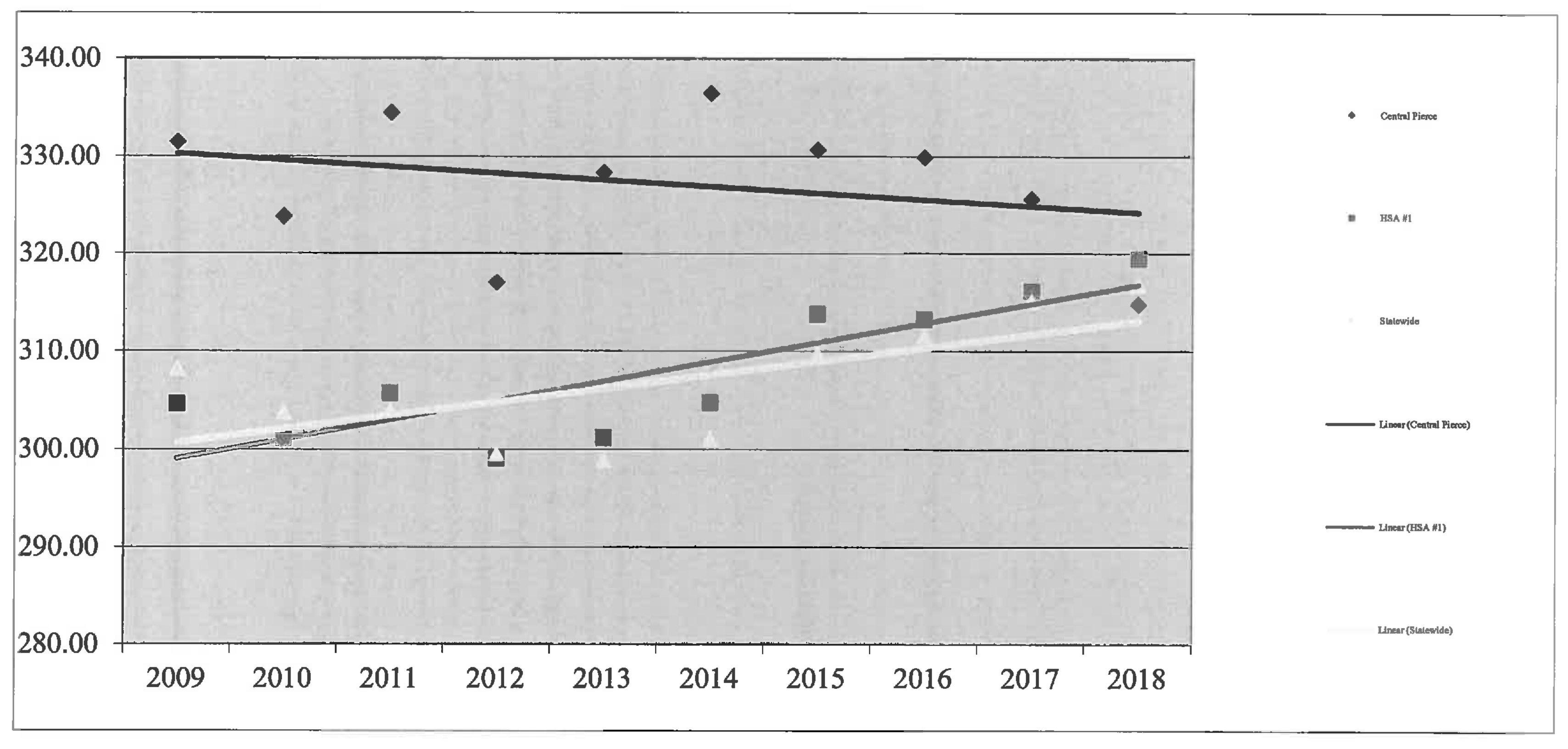
	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Southwest King	331.47	323.79	334.44	317.02	328.34	336.42	330.64	329.90	325.62	314.76
HSA # 1	304.59	301.13	305.70	299.11	301.20	304.78	313.75	313.21	316.16	319.50
Statewide Total	308.23	303.76	303.93	299.58	298.89	301.10	309.80	311.54	315.11	316.75

STEP 4: Historical Use Rate Trend Lines and Slopes

4-A. 2009-2018 Total Use Rates Per 1,000 (from Step 3-C.)

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Southwest King	331.47	323.79	334.44	317.02	328.34	336.42	330.64	329.90	325.62	314.76
HSA# 1	304.59	301.13	305.70	299.11	301.20	304.78	313.75	313.21	316.16	319.50
Statewide Total	308.23	303.76	303.93	299.58	298.89	301.10	309.80	311.54	315.11	316.75

4-B. 2009-2018 Total Use Rate Trend Lines



4-C. 2009-2018 Total Use Rate Slopes

HSA#1	1.97
Statewide Total	1.38

STEP 5: **Allocation of Patient (Provider) Days Back to Planning Areas Where the Patients Live**

5-A. **2018 (Provider) Days by Age and Residence**

Excludes MDC 19 ,MDC 15, Rehab

Southwest King

	Total Patient Days	Out-of-State Days	Total Less Out-of-State	% Out-of-State	
Age 0-64	15,067	276	14,791	1.83%	
Age 65+	14,809	310	14,499	2.09%	
Total	29,876	586	29,290	1.96%	

Other Washington (WA-Southwest King)

	Total Patient Days	Out-of-State Days	Total Less Out-of-State	% Out-of-State	
Age 0-64	1,284,436	61,481	1,222,955	4.79%	
Age 65+	1,128,958	44,282	1,084,676	3.92%	
Total	2,413,394	105,763	2,307,631	4.38%	

2,443,270

5-B. **2018 Patient Days by Age and Residence, to Providers by Area**

Excludes MDC 19 , MDC 15, Rehab

Residents of Southwest King

	To Planning Area Providers	To Other WA Providers	Total Resident Days (Excl. Out-of-State)
Age 0-64	10,230	37,681	47,911
Age 65+	12,159	27,725	39,884
Total	**22,389**	**65,406**	**87,795**

2018

Add (Patient) Days Provided in OR *	Total Resident Days
98	48,009
35	39,919
133	**87,928**

Tableau type-in for both

Other WA

Residents	To Planning Area Providers	To Other WA Providers	Total Resident Days (Excl. Out-of-State)
Age 0-64	4,999	1,247,857	1,252,856
Age 65+	2,739	1,104,804	1,107,543

Add (Patient) Days Provided in OR *	Total Resident Days
37,479	1,290,335
27,217	1,134,760

Total	7,738	2,352,661	2,360,399	64,696	2,425,095

5-C. **2018 Market Shares - Percentage of Total Resident Patient Days**
Excludes MDC 19, MDC 15, Rehab

Residents of Southwest King

	To Planning Area Providers	To Other WA Providers	To OR Providers	
Age 0-64	21.31%	78.49%	0.20%	100.00%
Age 65+	30.46%	69.45%	0.09%	100.00%
Total	**25.46%**	**74.39%**	**0.15%**	100.00%

Other WA Residents

Age 0-64	0.39%	96.71%	2.90%	100.00%
Age 65+	0.24%	97.36%	2.40%	100.00%
Total	**0.32%**	**97.01%**	**2.67%**	100.00%

STEP 6: Planning Area Use Rates by Age
Excludes MDC 19, MDC 15, Rehab

6-A. **2018 Population* by Age**

	Southwest King	Other WA
Age 0-64	227,320	5,997,941
Age 65+	39,190	1,131,646
Total	**266,510**	**7,129,587**

* Planning area population from Claritas 2017
Other WA population = Statewide population from OFM (2017), minus Planning Area population.

6-B. **2018 Use Rates by Age**
Excludes MDC 19, MDC 15, Rehab

	Southwest King	Other WA
Age 0-64	211.20	215.13
Age 65+	1,018.61	1,002.75
Total	**329.92**	**340.15**

STEP 7A: Planning Area Use Rates by Age

7A-A. 2018 Use Rates by Age (from Step 6-B)

Excludes MDC 19, MDC 15, Rehab, Mary Bridge

	Southwest King
Age 0-64	211.20
Age 65+	1,018.61
Total	**329.92**

7A-B. Projected Use Rates by Age for

Excludes MDC 19 , MDC 15, Rehab

	2018	2019	2020	2021	2022	2023	2024	2025	2026
Age 0-64 using HSATrend	211.20	213.16	215.13	217.10	219.06	221.03	223.00	224.96	226.93
Age 0-64 using State Trend	211.20	212.57	213.95	215.32	216.70	218.08	219.45	220.83	222.20
Age 65+ using HSA Trend	1,018.61	1,020.58	1,022.55	1,024.51	1,026.48	1,028.45	1,030.41	1,032.38	1,034.35
Age 65+ using State Trend	1,018.61	1,019.99	1,021.37	1,022.74	1,024.12	1,025.49	1,026.87	1,028.25	1,029.62

Trended Use Rates (from above) that are Closest to

Current Value - i.e., Requires the Smallest Adjustment

	2018	2019	2020	2021	2022	2023	2024	2025	2026
Age 0-64 using State Trend	211.20	212.57	213.95	215.32	216.70	218.08	219.45	220.83	222.20
Age 65+ using State Trend	1,018.61	1,019.99	1,021.37	1,022.74	1,024.12	1,025.49	1,026.87	1,028.25	1,029.62

THESE CALCULATIONS ENSURE THAT THE USE RATE CLOSEST TO THE CURRENT VALUE ALWAYS APPEARS IN ROWS 24 and 25 ABOVE

Calculate the Difference from current Use Rate

Age 0-64 using HSATrend	0.00	1.97	3.93	5.90	7.87	9.83	11.80	13.77	15.73
Age 0-64 using State Trend	0.00	1.38	2.75	4.13	5.50	6.88	8.26	9.63	11.01

Calculation to ensure the above values are positive.

Age 0-64 using stateTrend	0.00	1.97	3.93	5.90	7.87	9.83	11.80	13.77	15.73
Age 0-64 using State Trend	0.00	1.38	2.75	4.13	5.50	6.88	8.26	9.63	11.01

Calculate the Difference from current Use Rate

Age 65+ using HSA Trend	0.00	1.97	3.93	5.90	7.87	9.83	11.80	13.77	15.73
Age 65+ using State Trend	0.00	1.38	2.75	4.13	5.50	6.88	8.26	9.63	11.01

Calc: Ensures above values are posititve.

Age 65+ using HSA Trend	0.00	1.97	3.93	5.90	7.87	9.83	11.80	13.77	15.73
Age 65+ using State Trend	0.00	1.38	2.75	4.13	5.50	6.88	8.26	9.63	11.01

7A-A. 2018 Use Rates by Age (from Step 6-B)

Excludes MDC 19, MDC 15, Rehab

	Other WA
Age 0-64	215.13
Age 65+	1,002.75
Total	**340.15**

7A-B. Projected Use Rates by Age for
Excludes MDC 19, MDC 15, Rehab

	2018	2019	2020	2021	2022	2023	2024	2025	2026
Age 0-64 using HSATrend	215.13	217.10	219.06	221.03	223.00	224.96	226.93	228.90	230.86
Age 0-64 using State Trend	215.13	216.51	217.88	219.26	220.63	222.01	223.39	224.76	226.14
Age 65+ using HSA Trend	1,002.75	1,004.72	1,006.68	1,008.65	1,010.62	1,012.58	1,014.55	1,016.52	1,018.48
Age 65+ using State Trend	1,002.75	1,004.13	1,005.50	1,006.88	1,008.26	1,009.63	1,011.01	1,012.38	1,013.76

STEP 8: **Forecast Patient Days Using Trended Use Rates**

8A. Projected Use Rates by Age (from Step 7A-B.) for
Southwest King

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Age 0-64 using State Trend	211.20	212.57	213.95	215.32	216.70	218.08	219.45	220.83	222.20	223.58
Age 65+ using State Trend	1,018.61	1,019.99	1,021.37	1,022.74	1,024.12	1,025.49	1,026.87	1,028.25	1,029.62	1,031.00

8B. Projected Population* for
Southwest King

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	227,320	229,002	230,696	232,402	234,121	235,853	237,597	239,355	241,125	242,909
65+	39,190	40,980	42,853	44,811	46,859	49,000	51,239	53,581	56,029	58,590
Total	**266,510**	**269,982**	**273,549**	**277,213**	**280,980**	**284,853**	**288,837**	**292,936**	**297,155**	**301,499**

8C. Projected Resident Patient Days* for
Southwest King

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	48,009	48,679	49,357	50,042	50,734	51,434	52,141	52,856	53,579	54,310
65+	39,919	41,800	43,769	45,830	47,989	50,249	52,616	55,094	57,689	60,406
Total	**87,928**	**90,479**	**93,125**	**95,872**	**98,723**	**101,683**	**104,757**	**107,951**	**111,268**	**114,716**

Excludes MDC 19, MDC 15, Rehab, Mary Bridge

8A. Projected Use Rates by Age (from Step 7A-B.) for
Other WA

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Age 0-64 using State Trend	215.13	216.51	217.88	219.26	220.63	222.01	223.39	224.76	226.14	227.51
Age 65+ using State Trend	1002.75	1004.13	1005.50	1006.88	1008.26	1009.63	1011.01	1012.38	1013.76	1015.14

8B. Projected Population* for
Other WA

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	5,997,941	6,062,598	6,128,532	6,163,564	6,199,301	6,235,754	6,272,933	6,310,848	6,347,997	6,385,852
65+	1,131,646	1,182,646	1,236,342	1,280,878	1,327,515	1,376,372	1,427,574	1,481,253	1,518,092	1,556,694
Total	**7,129,587**	**7,245,244**	**7,364,874**	**7,444,442**	**7,526,816**	**7,612,126**	**7,700,507**	**7,792,101**	**7,866,089**	**7,942,546**

8c. Projected Resident Patient Days* for
Other Washington

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	1,290,335	1,312,587	1,335,296	1,351,411	1,367,777	1,384,401	1,401,288	1,418,442	1,435,527	1,452,875
65+	1,134,760	1,187,528	1,243,146	1,289,690	1,338,475	1,389,629	1,443,289	1,499,597	1,538,981	1,580,257
Total	**2,425,095**	**2,500,115**	**2,578,443**	**2,641,101**	**2,706,252**	**2,774,030**	**2,844,576**	**2,918,039**	**2,974,508**	**3,033,132**

STEP 9: Allocate Forecasted Patient Days to the Planning Areas Where Services are Expected to Be Provided

9A. (From Steps 8-C and D).

Projected Resident Patient Days* for Southwest King

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	48,009	48,679	49,357	50,042	50,734	51,434	52,141	52,856	53,579	54,310
65+	39,919	41,800	43,769	45,830	47,989	50,249	52,616	55,094	57,689	60,406
Total	**87,928**	**90,479**	**93,125**	**95,872**	**98,723**	**101,683**	**104,757**	**107,951**	**111,268**	**114,716**

Excludes MDC 19 , MDC 15, Rehab

Projected Resident Patient Days* for Other Washington

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	1,290,335	1,312,587	1,335,296	1,351,411	1,367,777	1,384,401	1,401,288	1,418,442	1,435,527	1,452,875
65+	1,134,760	1,187,528	1,243,146	1,289,690	1,338,475	1,389,629	1,443,289	1,499,597	1,538,981	1,580,257
Total	**2,425,095**	**2,500,115**	**2,578,443**	**2,641,101**	**2,706,252**	**2,774,030**	**2,844,576**	**2,918,039**	**2,974,508**	**3,033,132**

Excludes MDC 19, MDC 15, Rehab

9-B. 2018 Market Shares - Percentage of Total Resident Patient Days (From Step 5-C)

Excludes MDC 19, MDC 15, Rehab

Residents of Southwest King	To Planning Area Providers	To Other WA Providers	To OR Providers
Age 0-64	21.31%	78.49%	0.20%
Age 65+	30.46%	69.45%	0.09%
Total	**25.46%**	**74.39%**	**0.15%**

Other WA Residents

Age 0-64	0.39%	96.71%	2.90%
Age 65+	0.24%	97.36%	2.40%
Total	**0.32%**	**97.01%**	**2.67%**

9C. **Southwest King Resident Patient Days* to Southwest King Providers**

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	10,230	10,373	10,517	10,663	10,811	10,960	11,111	11,263	11,417	11,573
65+	12,159	12,732	13,332	13,960	14,617	15,306	16,026	16,781	17,572	18,399
Total	**22,389**	**23,105**	**23,849**	**24,623**	**25,428**	**26,265**	**27,137**	**28,044**	**28,989**	**29,972**

Southwest King
Resident Patient Days to Other Washington
Providers

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	37,681	38,207	38,739	39,276	39,820	40,369	40,924	41,486	42,053	42,626
65+	27,725	29,031	30,399	31,831	33,330	34,900	36,544	38,265	40,067	41,954
Total	**65,406**	**67,238**	**69,138**	**71,107**	**73,150**	**75,269**	**77,468**	**79,750**	**82,120**	**84,580**

Southwest King
Resident Patient Days to Oregon
Providers

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	98	99	101	102	104	105	106	108	109	111
65+	35	37	38	40	42	44	46	48	51	53
Total	**133**	**136**	**139**	**142**	**146**	**149**	**153**	**156**	**160**	**164**

9D. **Other Washington Resident Patient Days* to Southwest King Providers**

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	4,999	5,085	5,173	5,236	5,299	5,363	5,429	5,495	5,562	5,629
65+	2,739	2,866	3,001	3,113	3,231	3,354	3,484	3,620	3,715	3,814
Total	**7,738**	**7,952**	**8,174**	**8,349**	**8,530**	**8,718**	**8,913**	**9,115**	**9,276**	**9,443**

Other Washington Resident Patient Days to Other Washington Providers

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	1,247,857	1,269,377	1,291,338	1,306,922	1,322,750	1,338,827	1,355,157	1,371,747	1,388,269	1,405,046
65+	1,104,804	1,156,179	1,210,329	1,255,644	1,303,141	1,352,945	1,405,188	1,460,010	1,498,354	1,538,541
Total	**2,352,661**	**2,425,556**	**2,501,667**	**2,562,566**	**2,625,891**	**2,691,772**	**2,760,345**	**2,831,757**	**2,886,624**	**2,943,587**

Other Washington Resident Patient Days to Oregon Providers

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	37,479	38,125	38,785	39,253	39,728	40,211	40,702	41,200	41,696	42,200
65+	27,217	28,483	29,817	30,933	32,103	33,330	34,617	35,968	36,912	37,902
Total	**64,696**	**66,608**	**68,602**	**70,186**	**71,831**	**73,541**	**75,319**	**77,168**	**78,608**	**80,102**

9E. **Total Washington Resident Patient Days* to Southwest King Providers**

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	15,229	15,458	15,690	15,899	16,110	16,323	16,539	16,758	16,978	17,201
65+	14,898	15,598	16,332	17,073	17,848	18,660	19,510	20,401	21,286	22,213
Total	**30,127**	**31,056**	**32,023**	**32,971**	**33,957**	**34,983**	**36,050**	**37,159**	**38,265**	**39,415**

Total Washington Resident Patient Days* to Other Washington Providers

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	1,285,538	1,307,584	1,330,077	1,346,199	1,362,570	1,379,196	1,396,081	1,413,232	1,430,322	1,447,673
65+	1,132,529	1,185,210	1,240,728	1,287,475	1,336,471	1,387,845	1,441,731	1,498,275	1,538,421	1,580,494
Total	**2,418,067**	**2,492,794**	**2,570,805**	**2,633,673**	**2,699,041**	**2,767,041**	**2,837,813**	**2,911,507**	**2,968,743**	**3,028,167**

Total Washington Resident Patient Days* to Oregon Providers

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	37,577	38,225	38,886	39,355	39,832	40,316	40,808	41,308	41,806	42,311
65+	27,252	28,519	29,855	30,973	32,145	33,374	34,663	36,016	36,963	37,955
Total	**64,829**	**66,744**	**68,741**	**70,328**	**71,977**	**73,690**	**75,471**	**77,324**	**78,768**	**80,266**

9-F. Percent Out-of-State Resident Patient Days * (From Step 5-A)

Southwest King

	% Out-of-State	
Age 0-64	1.83%	
Age 65+	2.09%	
Total	**1.96%**	

Other Washington

Age 0-64	4.79%	
Age 65+	3.92%	
Total	**4.38%**	

<u>9-F.</u> Total Patient Days*, Including Out-of-State Residents

Southwest King

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	15,508	15,741	15,978	16,190	16,405	16,622	16,842	17,065	17,289	17,516
65+	15,210	15,925	16,674	17,430	18,221	19,050	19,919	20,828	21,732	22,678
Total	**30,718**	**31,666**	**32,652**	**33,620**	**34,626**	**35,673**	**36,761**	**37,893**	**39,021**	**40,195**

Southwest King
Provider Market Share of All Planning Area Resident Days

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Total	25.46%	25.54%	25.61%	25.68%	25.76%	25.83%	25.90%	25.98%	26.05%	26.13%

Southwest King
Inmigration Days

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Total	8,329	8,561	8,803	8,997	9,198	9,407	9,624	9,849	10,033	10,223

Excludes MDC 19, MDC 15, Rehab

STEP 10: Apply Weighted Occupancy Standard to Determine Bed Need

2018 BASELINE

Final Bed Need Calculations

Excludes MDC 19, MDC 15, Rehab

Southwest King

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Population 0-64	227,320	229,002	230,696	232,402	234,121	235,853	237,597	239,355	241,125	242,909
0-64 Use Rate	211.20	212.57	213.95	215.32	216.70	218.08	219.45	220.83	222.20	223.58
Population 65+	39,190	40,980	42,853	44,811	46,859	49,000	51,239	53,581	56,029	58,590
65+ Use Rate	1,018.61	1,019.99	1,021.37	1,022.74	1,024.12	1,025.49	1,026.87	1,028.25	1,029.62	1,031.00
Total Population	266,510	269,982	273,549	277,213	280,980	284,853	288,837	292,936	297,155	301,499
Total Area Resident Days	87,928	90,479	93,125	95,872	98,723	101,683	104,757	107,951	111,268	114,716
Total Days in Area Hospitals	30,718	31,666	32,652	33,620	34,626	35,673	36,761	37,893	39,021	40,195
Planning Area Available Beds										
Highline Medical Center	128	128	128	128	128	128	128	128	128	128
TOTAL	128	128	128	128	128	128	128	128	128	128
Weighted Occupancy Standard	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%
Gross Bed Need	129	133	138	142	146	150	155	160	164	169
Net Bed Need / Surplus	1	5	10	14	18	22	27	32	36	41

Acute Bed Methodology
from CHARS

Step 1

1. 2009-2018 Total Resident Days

Excludes MDC 19 and MDC 15, Rehab Service Line

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Southwest King	78,913	77,469	81,073	77,944	82,129	86,021	86,432	87,460	87,834	85,875
HSA# 1	1,273,445	1,267,477	1,295,218	1,277,547	1,299,353	1,339,232	1,406,024	1,432,166	1,474,392	1,504,972
Statewide Total	2,058,647	2,044,196	2,058,891	2,045,627	2,060,462	2,109,252	2,206,003	2,256,175	2,323,198	2,363,159

<u>STEP 2:</u> Total Resident Days Adjusted to Exclude All Psychiatric Patient Days

<u>2-A.</u> 2009-2018 Total Resident Days (from Step 1)
Excludes MDC 19, MDC 15, Rehab

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Southwest King	78,913	77,469	81,073	77,944	82,129	86,021	86,432	87,460	87,834	85,875
HSA# 1	1,273,445	1,267,477	1,295,218	1,277,547	1,299,353	1,339,232	1,406,024	1,432,166	1,474,392	1,504,972
Statewide Total	2,058,647	2,044,196	2,058,891	2,045,627	2,060,462	2,109,252	2,206,003	2,256,175	2,323,198	2,363,159

<u>2-B. 2009-2018 Total Psychiatric Hospital Non-MDC 19 Patient Days</u>
Excludes MDC 19, MDC 15, Rehab

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Southwest King	62	66	62	121	429	1154	1858	1882	2155	2,009
HSA# 1	1816	1384	1639	2907	3101	9823	16266	15326	16222	16,235
Statewide Total	2119	1563	1916	3185	3410	11148	18411	18138	19685	20467

<u>NOTE:</u> Relevant to this Step, there are 4 psychiatric hospitals statewide:

Fairfax Hospital, Kirkland: ***Located in HSA 1 and East King Planning Area***
Navos, Seattle: ***Located in HSA 1 and Southwest King Planning Area***
Lourdes Counseling Center, Richland: ***Located in HSA 3 and Benton-Franklin Planning Area***

<u>2C.</u> 2009-2018 Total Resident Days Adjusted to Exclude All Psychiatric Patient Days
Excludes MDC 19, MDC 15, Rehab

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Southwest King	78,851	77,403	81,011	77,823	81,700	84,867	84,574	85,578	85,679	83,866
HSA# 1	1,271,629	1,266,093	1,293,579	1,274,640	1,296,252	1,329,409	1,389,758	1,416,840	1,458,170	1,488,737
Statewide Total	2,056,528	2,042,633	2,056,975	2,042,442	2,057,052	2,098,104	2,187,592	2,238,037	2,303,513	2,342,692

STEP 3: Historical Average Use Rates

3-A. 2009-2018 Total Resident Days Adjusted to Exclude All Psychiatric Patient Days (from Step 2-C.)

Excludes MDC 19, MDC 15, Rehab, Mary Bridge

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Southwest King	78,851	77,403	81,011	77,823	81,700	84,867	84,574	85,578	85,679	83,866
HSA# 1	1,271,629	1,266,093	1,293,579	1,274,640	1,296,252	1,329,409	1,389,758	1,416,840	1,458,170	1,488,737
Statewide Total	2,056,528	2,042,633	2,056,975	2,042,442	2,057,052	2,098,104	2,187,592	2,238,037	2,303,513	2,342,692

3-B. 2009-2018 Total Populations

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Southwest King	237,881	239,050	242,228	245,487	248,830	252,261	255,785	259,406	263,128	266,448
HSA # 1	4,174,871	4,204,534	4,231,500	4,261,500	4,303,625	4,361,850	4,429,440	4,523,580	4,612,100	4,659,617
Statewide Total	6,672,159	6,724,540	6,767,900	6,817,770	6,882,400	6,968,170	7,061,410	7,183,700	7,310,300	7,396,097

3-C. 2009-2018 Total Use Rates Per 1,000

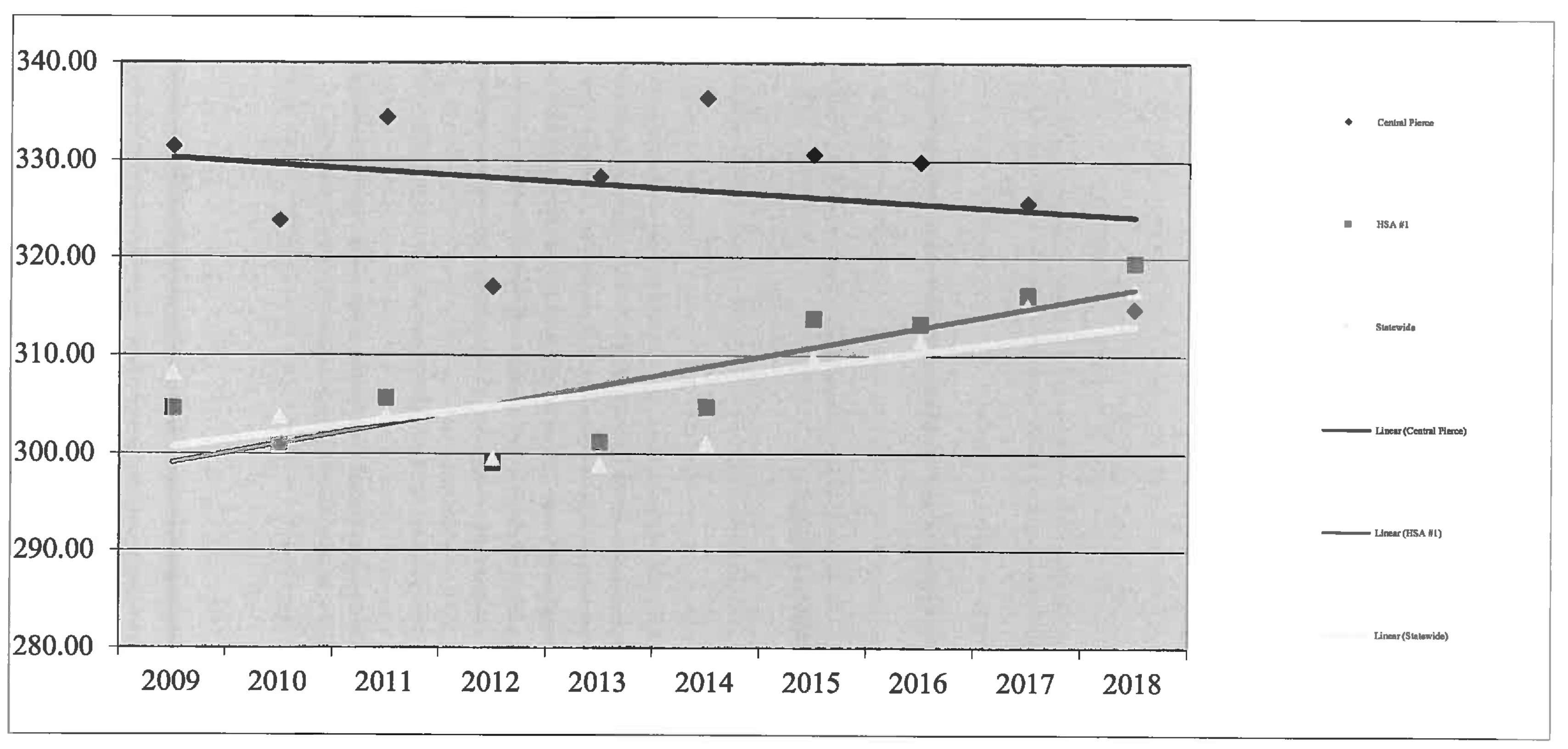
	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Southwest King	331.47	323.79	334.44	317.02	328.34	336.42	330.64	329.90	325.62	314.76
HSA # 1	304.59	301.13	305.70	299.11	301.20	304.78	313.75	313.21	316.16	319.50
Statewide Total	308.23	303.76	303.93	299.58	298.89	301.10	309.80	311.54	315.11	316.75

STEP 4: Historical Use Rate Trend Lines and Slopes

4-A. 2009-2018 Total Use Rates Per 1,000 (from Step 3-C.)

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Southwest King	331.47	323.79	334.44	317.02	328.34	336.42	330.64	329.90	325.62	314.76
HSA# 1	304.59	301.13	305.70	299.11	301.20	304.78	313.75	313.21	316.16	319.50
Statewide Total	308.23	303.76	303.93	299.58	298.89	301.10	309.80	311.54	315.11	316.75

4-B. 2009-2018 Total Use Rate Trend Lines



4-C. 2009-2018 Total Use Rate Slopes

HSA#1	1.97
Statewide Total	1.38

STEP 5: Allocation of Patient (Provider) Days Back to Planning Areas Where the Patients Live

5-A. 2018 (Provider) Days by Age and Residence

Excludes MDC 19 ,MDC 15, Rehab

Southwest King

	Total Patient Days	Out-of-State Days	Total Less Out-of-State	% Out-of-State	
Age 0-64	13,775	244	13,531	1.77%	
Age 65+	13,539	274	13,265	2.02%	
Total	27,314	518	26,796	1.90%	

Other Washington (WA-Southwest King)

	Total Patient Days	Out-of-State Days	Total Less Out-of-State	% Out-of-State	
Age 0-64	1,284,436	61,481	1,222,955	4.79%	
Age 65+	1,128,958	44,282	1,084,676	3.92%	
Total	2,413,394	105,763	2,307,631	4.38%	

2,440,708

5-B. 2018 Patient Days by Age and Residence, to Providers by Area

Excludes MDC 19 , MDC 15, Rehab

Residents of Southwest King

2018

	To Planning Area Providers	To Other WA Providers	Total Resident Days (Excl. Out-of-State)	Add (Patient) Days Provided in OR *	Total Resident Days
Age 0-64	9,353	37,681	47,034	98	47,132
Age 65+	11,116	27,725	38,841	35	38,876
Total	20,469	65,406	85,875	133	86,008

Other WA

Residents	To Planning Area Providers	To Other WA Providers	Total Resident Days (Excl. Out-of-State)	Add (Patient) Days Provided in OR *	Total Resident Days
Age 0-64	4,422	1,248,434	1,252,856	37,479	1,290,335
Age 65+	2,423	1,105,120	1,107,543	27,217	1,134,760

Total	6,845	2,353,554	2,360,399	64,696	2,425,095

5-C. **2018 Market Shares - Percentage of Total Resident Patient Days**
Excludes MDC 19, MDC 15, Rehab

Residents of Southwest King

	To Planning Area Providers	To Other WA Providers	To OR Providers	
Age 0-64	19.84%	79.95%	0.21%	100.00%
Age 65+	28.59%	71.32%	0.09%	100.00%
Total	**23.80%**	**76.05%**	**0.15%**	100.00%

Other WA Residents

Age 0-64	0.34%	96.75%	2.90%	100.00%
Age 65+	0.21%	97.39%	2.40%	100.00%
Total	**0.28%**	**97.05%**	**2.67%**	100.00%

STEP 6: **Planning Area Use Rates by Age**
Excludes MDC 19, MDC 15, Rehab

6-A. **2018 Population* by Age**

	Southwest King	Other WA
Age 0-64	227,320	5,997,941
Age 65+	39,190	1,131,646
Total	**266,510**	**7,129,587**

* Planning area population from Claritas 2017

Other WA population = Statewide population from OFM (2017), minus Planning Area population.

6-B. **2018 Use Rates by Age**
Excludes MDC 19, MDC 15, Rehab

	Southwest King	Other WA
Age 0-64	207.34	215.13
Age 65+	992.00	1,002.75
Total	**322.72**	**340.15**

STEP 7A: Planning Area Use Rates by Age

7A-A. 2018 Use Rates by Age (from Step 6-B)

Excludes MDC 19, MDC 15, Rehab, Mary Bridge

	King
Age 0-64	207.34
Age 65+	992.00
Total	**322.72**

7A-B. Projected Use Rates by Age for

Excludes MDC 19 , MDC 15, Rehab

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Age 0-64 using HSATrend	207.34	209.30	211.27	213.24	215.20	217.17	219.14	221.10	223.07	225.04
Age 0-64 using State Trend	207.34	208.71	210.09	211.47	212.84	214.22	215.59	216.97	218.35	219.72
Age 65+ using HSA Trend	992.00	993.97	995.93	997.90	999.87	1,001.83	1,003.80	1,005.76	1,007.73	1,009.70
Age 65+ using State Trend	992.00	993.37	994.75	996.13	997.50	998.88	1,000.26	1,001.63	1,003.01	1,004.38

Trended Use Rates (from above) that are Closest to

Current Value - i.e., Requires the Smallest Adjustment

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Age 0-64 using State Trend	207.34	208.71	210.09	211.47	212.84	214.22	215.59	216.97	218.35	219.72
Age 65+ using State Trend	992.00	993.37	994.75	996.13	997.50	998.88	1,000.26	1,001.63	1,003.01	1,004.38

THESE CALCULATIONS ENSURE THAT THE USE RATE CLOSEST TO THE CURRENT VALUE ALWAYS APPEARS IN ROWS 24 and 25 ABOVE

Calculate the Difference from current Use Rate

Age 0-64 using HSATrend	0.00	1.97	3.93	5.90	7.87	9.83	11.80	13.77	15.73	17.70
Age 0-64 using State Trend	0.00	1.38	2.75	4.13	5.50	6.88	8.26	9.63	11.01	12.39

Calculation to ensure the above values are posititve.

Age 0-64 using stateTrend	0.00	1.97	3.93	5.90	7.87	9.83	11.80	13.77	15.73	17.70
Age 0-64 using State Trend	0.00	1.38	2.75	4.13	5.50	6.88	8.26	9.63	11.01	12.39

Calculate the Difference from current Use Rate

Age 65+ using HSA Trend	0.00	1.97	3.93	5.90	7.87	9.83	11.80	13.77	15.73	17.70
Age 65+ using State Trend	0.00	1.38	2.75	4.13	5.50	6.88	8.26	9.63	11.01	12.39

Calc: Ensures above values are posititve.

Age 65+ using HSA Trend	0.00	1.97	3.93	5.90	7.87	9.83	11.80	13.77	15.73	17.70
Age 65+ using State Trend	0.00	1.38	2.75	4.13	5.50	6.88	8.26	9.63	11.01	12.39

7A-A. 2018 Use Rates by Age (from Step 6-B)

Excludes MDC 19, MDC 15, Rehab

	Other WA
Age 0-64	215.13
Age 65+	1,002.75
Total	**340.15**

7A-B. Projected Use Rates by Age for

Excludes MDC 19, MDC 15, Rehab

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Age 0-64 using HSATrend	215.13	217.10	219.06	221.03	223.00	224.96	226.93	228.90	230.86	232.83
Age 0-64 using State Trend	215.13	216.51	217.88	219.26	220.63	222.01	223.39	224.76	226.14	227.51
Age 65+ using HSA Trend	1,002.75	1,004.72	1,006.68	1,008.65	1,010.62	1,012.58	1,014.55	1,016.52	1,018.48	1,020.45
Age 65+ using State Trend	1,002.75	1,004.13	1,005.50	1,006.88	1,008.26	1,009.63	1,011.01	1,012.38	1,013.76	1,015.14

STEP 8: Forecast Patient Days Using Trended Use Rates

8A. Projected Use Rates by Age (from Step 7A-B.) for
Southwest King

	2018	2019	2020	2021	2022	2023	2024	2025
Age 0-64 using State Trend	207.34	208.71	210.09	211.47	212.84	214.22	215.59	216.97
Age 65+ using State Trend	992.00	993.37	994.75	996.13	997.50	998.88	1,000.26	1,001.63

8B. Projected Population* for
Southwest King

	2018	2019	2020	2021	2022	2023	2024	2025
0-64	227,320	229,002	230,696	232,402	234,121	235,853	237,597	239,355
65+	39,190	40,980	42,853	44,811	46,859	49,000	51,239	53,581
Total	**266,510**	**269,982**	**273,549**	**277,213**	**280,980**	**284,853**	**288,837**	**292,936**

8C. Projected Resident Patient Days* for
Southwest King

	2018	2019	2020	2021	2022	2023	2024	2025
0-64	47,132	47,796	48,467	49,145	49,831	50,524	51,225	51,933
65+	38,876	40,709	42,628	44,638	46,742	48,945	51,253	53,668
Total	**86,008**	**88,505**	**91,095**	**93,783**	**96,573**	**99,469**	**102,477**	**105,601**

Excludes MDC 19, MDC 15, Rehab, Mary Bridge

8A. Projected Use Rates by Age (from Step 7A-B.) for
Other WA

	2018	2019	2020	2021	2022	2023	2024	2025
Age 0-64 using State Trend	215.13	216.51	217.88	219.26	220.63	222.01	223.39	224.76
Age 65+ using State Trend	1002.75	1004.13	1005.50	1006.88	1008.26	1009.63	1011.01	1012.38

8B. Projected Population* for
Other WA

	2018	2019	2020	2021	2022	2023	2024	2025
0-64	5,997,941	6,062,598	6,128,532	6,163,564	6,199,301	6,235,754	6,272,933	6,310,848
65+	1,131,646	1,182,646	1,236,342	1,280,878	1,327,515	1,376,372	1,427,574	1,481,253
Total	**7,129,587**	**7,245,244**	**7,364,874**	**7,444,442**	**7,526,816**	**7,612,126**	**7,700,507**	**7,792,101**

8c. Projected Resident Patient Days* for
Other Washington

	2018	2019	2020	2021	2022	2023	2024	2025
0-64	1,290,335	1,312,587	1,335,296	1,351,411	1,367,777	1,384,401	1,401,288	1,418,442
65+	1,134,760	1,187,528	1,243,146	1,289,690	1,338,475	1,389,629	1,443,289	1,499,597
Total	**2,425,095**	**2,500,115**	**2,578,443**	**2,641,101**	**2,706,252**	**2,774,030**	**2,844,576**	**2,918,039**

STEP 9: Allocate Forecasted Patient Days to the Planning Areas Where Services are Expected to Be Provided

9A. (From Steps 8-C and D).

Projected Resident Patient Days* for Southwest King

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	47,132	47,796	48,467	49,145	49,831	50,524	51,225	51,933	52,649	53,373
65+	38,876	40,709	42,628	44,638	46,742	48,945	51,253	53,668	56,198	58,847
Total	**86,008**	**88,505**	**91,095**	**93,783**	**96,573**	**99,469**	**102,477**	**105,601**	**108,847**	**112,219**

Excludes MDC 19 , MDC 15, Rehab

Projected Resident Patient Days* for Other Washington

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	1,290,335	1,312,587	1,335,296	1,351,411	1,367,777	1,384,401	1,401,288	1,418,442	1,435,527	1,452,875
65+	1,134,760	1,187,528	1,243,146	1,289,690	1,338,475	1,389,629	1,443,289	1,499,597	1,538,981	1,580,257
Total	**2,425,095**	**2,500,115**	**2,578,443**	**2,641,101**	**2,706,252**	**2,774,030**	**2,844,576**	**2,918,039**	**2,974,508**	**3,033,132**

Excludes MDC 19, MDC 15, Rehab

9-B. 2018 Market Shares - Percentage of Total Resident Patient Days (From Step 5-C)

Excludes MDC 19, MDC 15, Rehab

Residents of Southwest King

	To Planning Area Providers	To Other WA Providers
Age 0-64	19.84%	79.95%
Age 65+	28.59%	71.32%
Total	**23.80%**	**76.05%**

To OR Providers
0.21%
0.09%
0.15%

Other WA Residents

Age 0-64	0.34%	96.75%	2.90%
Age 65+	0.21%	97.39%	2.40%
Total	**0.28%**	**97.05%**	**2.67%**

9C. **Southwest King Resident Patient Days* to Southwest King Providers**

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	9,353	9,485	9,618	9,752	9,889	10,026	10,165	10,306	10,448	10,591
65+	11,116	11,640	12,189	12,763	13,365	13,995	14,655	15,346	16,069	16,826
Total	**20,469**	**21,125**	**21,807**	**22,516**	**23,254**	**24,021**	**24,820**	**25,651**	**26,517**	**27,418**

Southwest King
Resident Patient Days to Other Washington Providers

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	37,681	38,212	38,748	39,290	39,839	40,393	40,953	41,519	42,092	42,670
65+	27,725	29,032	30,401	31,834	33,335	34,906	36,551	38,274	40,078	41,967
Total	**65,406**	**67,244**	**69,149**	**71,124**	**73,173**	**75,299**	**77,504**	**79,794**	**82,170**	**84,637**

Southwest King
Resident Patient Days to Oregon Providers

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	98	99	101	102	104	105	107	108	109	111
65+	35	37	38	40	42	44	46	48	51	53
Total	**133**	**136**	**139**	**142**	**146**	**149**	**153**	**156**	**160**	**164**

9D. **Other Washington Resident Patient Days* to Southwest King Providers**

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	4,422	4,498	4,576	4,631	4,687	4,744	4,802	4,861	4,920	4,979
65+	2,423	2,536	2,654	2,754	2,858	2,967	3,082	3,202	3,286	3,374
Total	**6,845**	**7,034**	**7,231**	**7,385**	**7,545**	**7,712**	**7,884**	**8,063**	**8,206**	**8,353**

Other Washington Resident Patient Days to Other Washington Providers

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	1,248,434	1,269,964	1,291,935	1,307,526	1,323,362	1,339,446	1,355,784	1,372,381	1,388,911	1,405,696
65+	1,105,120	1,156,510	1,210,675	1,256,003	1,303,514	1,353,332	1,405,590	1,460,428	1,498,783	1,538,981
Total	**2,353,554**	**2,426,473**	**2,502,611**	**2,563,530**	**2,626,875**	**2,692,778**	**2,761,373**	**2,832,809**	**2,887,694**	**2,944,677**

Other Washington Resident Patient Days to Oregon Providers

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	37,479	38,125	38,785	39,253	39,728	40,211	40,702	41,200	41,696	42,200
65+	27,217	28,483	29,817	30,933	32,103	33,330	34,617	35,968	36,912	37,902
Total	**64,696**	**66,608**	**68,602**	**70,186**	**71,831**	**73,541**	**75,319**	**77,168**	**78,608**	**80,102**

9E. **Total Washington Resident Patient Days* to Southwest King Providers**

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	13,775	13,983	14,194	14,384	14,576	14,770	14,967	15,167	15,367	15,570
65+	13,539	14,176	14,843	15,517	16,223	16,962	17,737	18,548	19,355	20,201
Total	**27,314**	**28,159**	**29,037**	**29,901**	**30,799**	**31,733**	**32,704**	**33,714**	**34,722**	**35,771**

Total Washington Resident Patient Days* to
Other Washington Providers

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	1,286,115	1,308,175	1,330,683	1,346,817	1,363,200	1,379,838	1,396,737	1,413,900	1,431,003	1,448,366
65+	1,132,845	1,185,542	1,241,076	1,287,837	1,336,849	1,388,238	1,442,141	1,498,702	1,538,861	1,580,948
Total	**2,418,960**	**2,493,717**	**2,571,760**	**2,634,654**	**2,700,049**	**2,768,077**	**2,838,878**	**2,912,602**	**2,969,864**	**3,029,314**

Total Washington Resident Patient Days* to
Oregon Providers

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-64	37,577	38,225	38,886	39,355	39,832	40,316	40,808	41,308	41,806	42,311
65+	27,252	28,519	29,855	30,973	32,145	33,374	34,663	36,016	36,963	37,955
Total	**64,829**	**66,744**	**68,741**	**70,328**	**71,977**	**73,690**	**75,471**	**77,324**	**78,768**	**80,266**

9-F. Percent Out-of-State Resident Patient Days * (From Step 5-A)

Southwest King

	% Out-of-State	
Age 0-64	1.77%	
Age 65+	2.02%	
Total	**1.90%**	

Other Washington

Age 0-64	4.79%	
Age 65+	3.92%	
Total	**4.38%**	

2018 BASELINE

Final Bed Need Calculations

Excludes MDC 19, MDC 15, Rehab

Southwest King

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Population 0-64	227,320	229,002	230,696	232,402	234,121	235,853	237,597	239,355	241,125	242,909
0-64 Use Rate	207.34	208.71	210.09	211.47	212.84	214.22	215.59	216.97	218.35	219.72
Population 65+	39,190	40,980	42,853	44,811	46,859	49,000	51,239	53,581	56,029	58,590
65+ Use Rate	992.00	993.37	994.75	996.13	997.50	998.88	1,000.26	1,001.63	1,003.01	1,004.38
Total Population	266,510	269,982	273,549	277,213	280,980	284,853	288,837	292,936	297,155	301,499
Total Area Resident Days	86,008	88,505	91,095	93,783	96,573	99,469	102,477	105,601	108,847	112,219
Total Days in Area Hospitals	27,832	28,693	29,589	30,470	31,386	32,338	33,328	34,358	35,386	36,456
Planning Area Available Beds										
Highline Medical Center	128	128	128	128	128	128	128	128	128	128
TOTAL	128	128	128	128	128	128	128	128	128	128
Weighted Occupancy Standard	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%
Gross Bed Need	117	121	125	128	132	136	140	145	149	154
Net Bed Need / Surplus	-11	-7	-3	0	4	8	12	17	21	26

Exhibit 5
Pro Forma Financials and Assumptions

Hospital with the Project

St. Anne Hospital

Financial Assumptions

The underlying assumptions are detailed below:

Overall (hospital wide) Assumptions:

- Charity care: assumed to be 0.9% (based on 2019) of gross inpatient revenue; overall charity care is assumed to be about 1.4%.
- Bad Debt: assumed to be 1.4% of gross revenue (based on 2019).
- All information provided in current dollars. No inflation is assumed.
- Project start date 4/1/2021
- Deductions from Revenue are provided for the hospital with and without the project.
- Gross patient revenue was calculated using the same rates and utilization of services as in the baseline period of 2019. Payer mix associated with med/surg volumes was kept constant. No reimbursement changes were used in the pro forma. Thus, the net patient revenue per case is the same as the baseline period of 2019. Incremental revenue per discharge was assumed to be $16,772.
- Other operating revenue which includes cafeteria and gift shop purchases, was assumed to be $35 per discharge.
- Salary expense corresponds to the FTEs needed to provide the service. FTEs increase in accordance with the increase in patient days. This level of productivity is based upon the productivity that occurred in 2019. The statement does not include any compensation increases.
- Employee benefits are kept at the same percentage of salary as 2019 or 27% throughout the projection period.
- Purchased services-other: This line item contains fees paid to CHI Franciscan's parent company, CHI, for services provided to CHI Franciscan such as Legal, Compliance, Information Technology, and Revenue Cycle. This line item also includes payments to vendors for such things as, laundry service, security services, etc. Several of St. Anne's support departments, such as Dietary, are managed by outside companies that have expertise in managing these types of service. Payments for these type of management services are included in this expense category. This was assumed to $202 per discharge.
- Supplies expense increases proportionate to the increase in patient days. Supplies were assumed to be $2,178 per discharge.
- No increases in utilities, depreciation, rentals and leases, insurance, repairs and maintenance, license and taxes or interest were assumed for the project.
- No additional patient days were assumed without the project

Total Staffing for SANH With Bed Addition, 2019-2024						
	Actual 2019	**Total 2020**	**Total 2021**	**Total 2022**	**Total 2023**	**Total 2024**
Nursing						
Management	3	3	5	6	6	6
RN	392	392	394	396	398	400
LPN	0	0	0	0	0	0
Patient Care Asst	160	162	162	163	163	164
Tech/Professional	10	10	10	10	10	11
Svc/Support	2	2	2	2	2	2
Ancillary/Support						
Management	21	21	21	21	21	21
RN	194	194	195	195	196	196
LPN	2	2	2	2	2	2
Patient Care Asst	200	200	202	202	203	203
Tech/Professional	177	177	179	181	183	185
Svc/Support	156	156	156	157	157	157
Total	1,317	1,320	1,328	1,335	1,341	1,347
Salaries & Wages/FTE	$46,395	$46,362	$46,437	$46,465	$46,479	$46,464
Employee Benefits/FTE	$12,458	$12,449	$12,469	$12,476	$12,480	$12,476
Total Salaries & Wages, Benefits/FTE	$58,852	$58,811	$58,906	$58,941	$58,959	$58,941
Patient Days	31,721	32,010	32,970	34,289	35,661	36,909

Salaries & Wages/FTE	**Actual 2019**	**Total 2020**	**Total 2021**	**Total 2022**	**Total 2023**	**Total 2024**
Nursing						
Management	$364,251	$364,251	$531,036	$637,243	$637,243	$637,243
RN	$18,365,023	$18,371,539	$18,465,271	$18,559,003	$18,652,736	$18,746,468
LPN	$0	$0	$0	$0	$0	$0
Patient Care Asst	$4,060,546	$4,107,683	$4,107,683	$4,133,039	$4,133,039	$4,158,395
Tech/Professional	$387,231	$401,885	$401,885	$401,885	$401,885	$442,074
Svc/Support	$58,851	$58,851	$58,851	$58,851	$58,851	$58,851
Ancillary/Support						
Management	$2,919,440	$2,919,440	$2,919,440	$2,919,440	$2,919,440	$2,919,440
RN	$12,215,427	$12,215,427	$12,256,881	$12,256,881	$12,319,737	$12,319,737
LPN	$111,001	$111,001	$111,001	$111,001	$111,001	$111,001
Patient Care Asst	$8,058,567	$8,068,381	$8,149,064	$8,149,064	$8,189,406	$8,189,406
Tech/Professional	$8,849,330	$8,849,330	$8,949,166	$9,049,002	$9,148,839	$9,248,675
Svc/Support	$5,588,265	$5,588,265	$5,596,653	$5,632,529	$5,632,529	$5,632,529
Total Salaries and Wages	$60,977,931	$61,056,051	$61,546,931	$61,907,939	$62,204,705	$62,463,818
PTO	$125,920	$126,081	$127,095	$127,841	$128,453	$128,989
Total Salaries and Wages + PTO	$61,103,851	$61,182,133	$61,674,026	$62,035,779	$62,333,158	$62,592,807
Incremental Salaries and Wages	$0	$78,281	$570,175	$931,928	$1,229,307	$1,488,955
Total Benefits	$16,407,182	$16,428,202	$16,560,281	$16,657,417	$16,737,267	$16,806,986
Incremental Benefits	$0	$21,020	$153,099	$250,235	$330,085	$399,804

HOSPITAL INFORMATION

DEDUCTIONS FROM REVENUE- HOSPITAL AGGREGATE WITH THE PROJECT

ACCT:	ITEM:	Actual 2017	Actual 2018	Actual 2019	PROJECTED 2020	PROJECTED 2021	PROJECTED 2022	PROJECTED 2023	PROJECTED 2024
5800	PROVISION FOR BAD DEBTS	$9,485,059	$7,052,593	$13,241,931	$13,270,063	$13,363,684	$13,492,354	$13,626,097	$13,747,389
	CONTRACTUAL ADJUSTMENTS								
5810	Medicare	$295,423,102	$322,734,946	$354,020,620	$356,105,240	$363,042,582	$372,577,155	$382,487,643	$391,475,431
5820	Medicaid	$191,352,348	$203,993,340	$198,724,020	$199,590,103	$202,472,316	$206,433,583	$210,551,028	$214,285,126
5830	Workers Compensation	$8,322,377	$8,358,545	$8,197,031	$8,210,220	$8,254,112	$8,314,437	$8,377,140	$8,434,005
5840	Other Government Programs	$8,588,769	$8,626,095	$8,459,411	$8,497,226	$8,623,068	$8,796,024	$8,975,799	$9,138,836
5850	Negotiated Rates	$134,676,104	$142,418,418	$159,944,402	$160,471,800	$162,226,911	$164,639,108	$167,146,409	$169,420,272
5860	Other	$36,424	$36,582	$35,875	$41,111	$58,536	$82,484	$107,377	$129,952
	Total Contractual Adjustments	**$638,399,124**	**$686,167,925**	**$729,381,359**	**$732,915,700**	**$744,677,524**	**$760,842,790**	**$777,645,396**	**$792,883,621**
	CHARITY CARE								
5900	Inpatient	$6,244,887	$9,442,296	$3,646,732	$3,721,751	$3,971,406	$4,314,526	$4,671,175	$4,994,619
5910	Outpatient	$11,179,771	$9,849,204	$11,487,662	$11,487,662	$11,487,662	$11,487,662	$11,487,662	$11,487,662
	Total Charity Care	$17,424,657	$19,291,500	$15,134,394	$15,209,413	$15,459,068	$15,802,188	$16,158,837	$16,482,281
5970	ADMINISTRATIVE ADJUSTMENTS	$10,242,415	$13,729,720	$13,756,743	$13,784,875	$13,878,496	$14,007,166	$14,140,909	$14,262,201
5980	OTHER DEDUCTIONS (Specify)	0		0	0	0	0	0	0
	TOTAL DEDUCTIONS FROM REVENUE	**$675,551,254**	**$726,241,738**	**$771,514,427**	**$775,180,052**	**$787,378,771**	**$804,144,498**	**$821,571,240**	**$837,375,492**

EXPLANATIONS:

Bad debt is St. Anne 12 months ending Sep 2020 - 0.72% of gross charges

Contractuals are based on all patients discharged during 2019.

Charity care is Highline 2019 1.6% of gross charges

HOSPITAL INFORMATION

COMPARISON STATEMENT OF REVENUE & EXPENSE-UNRESTRICTED FUNDS-HOSPITAL AGGREGATE WITH PROJECT

	Actual	Actual	Actual	PROJECTED	PROJECTED	PROJECTED	PROJECTED	PROJECTED
	2017	2018	2019	2020	2021	2022	2023	2024
OPERATING REVENUE:								
Inpatient Revenue	$386,407,364	$422,375,540	$403,341,854	$408,030,558	$423,633,950	$445,079,006	$467,369,566	$487,584,798
Outpatient Revenue	$470,900,948	$491,987,676	$552,433,997	$552,433,997	$552,433,997	$552,433,997	$552,433,997	$552,433,997
TOTAL PATIENT SERVICES REVENUE	$857,308,312	$914,363,216	$955,775,851	$960,464,555	$976,067,947	$997,513,003	$1,019,803,563	$1,040,018,795
DEDUCTIONS FROM REVENUE:								
Provision for Bad Debt	$9,485,059	$7,052,593	$13,241,931	$13,270,063	$13,363,684	$13,492,354	$13,626,097	$13,747,389
Contractual Adjustments	$638,399,124	$686,167,925	$729,381,359	$732,915,700	$744,677,524	$760,842,790	$777,645,396	$792,883,621
Charity and Uncompensated Care	$17,424,657	$19,291,500	$15,134,394	$15,209,413	$15,459,068	$15,802,188	$16,158,837	$16,482,281
Other Adjustments and Allowances	$10,242,415	$13,729,720	$13,756,743	$13,784,875	$13,878,496	$14,007,166	$14,140,909	$14,262,201
TOTAL DEDUCTIONS FROM REVENUE	$675,551,254	$726,241,738	$771,514,427	$775,180,052	$787,378,771	$804,144,498	$821,571,240	$837,375,492
NET PATIENT SERVICE REVENUE	$181,757,057	$188,121,478	$184,261,424	$185,284,503	$188,689,176	$193,368,505	$198,232,323	$202,643,303
OTHER OPERATING REVENUE								
Other Operating Revenue	$9,807,589	$10,454,884	$11,611,795	$11,613,930	$11,621,035	$11,625,913	$11,633,453	$11,640,291
Tax Revenues	$0	$0	$0	$0	$0	$0	$0	$0
TOTAL OTHER OPERATING REVENUE	$9,807,589	$10,454,884	$11,611,795	$11,613,930	$11,621,035	$11,625,913	$11,633,453	$11,640,291
TOTAL OPERATING REVENUE	$191,564,646	$198,576,363	$195,873,219	$196,898,433	$200,310,211	$204,994,418	$209,865,776	$214,283,594
OPERATING EXPENSES								
Salaries and Wages	$64,431,369	$62,240,065	$61,103,851	$61,182,132	$61,674,026	$62,035,779	$62,333,158	$62,592,806
Employee Benefits	$18,195,846	$17,375,839	$16,407,182	$16,428,202	$16,560,281	$16,657,417	$16,737,267	$16,806,986
Professional Fees	$6,455,605	$8,428,669	$9,287,563	$9,287,563	$9,287,563	$9,287,563	$9,287,563	$9,287,563
Supplies	$24,537,203	$24,034,251	$24,310,875	$24,443,733	$24,885,867	$25,436,514	$26,037,684	$26,582,883
Purchased Services - Utilities	$1,687,802	$1,625,454	$1,672,287	$1,672,287	$1,672,287	$1,672,287	$1,672,287	$1,672,287
Purchased Services - Other	$39,940,437	$46,371,880	$50,411,238	$50,423,560	$50,464,566	$50,508,978	$50,561,178	$50,608,518
Depreciation	$12,049,316	$13,934,082	$14,244,947	$14,244,947	$14,244,947	$14,244,947	$14,244,947	$14,244,947
Rentals and Leases	$2,278,864	$1,962,105	$1,675,676	$1,675,676	$1,675,676	$1,675,676	$1,675,676	$1,675,676
Repairs and Maintenance	$742,871	$1,085,757	$1,361,217	$1,361,217	$1,361,217	$1,361,217	$1,361,217	$1,361,217
Insurance	$1,877,187	$1,812,907	$1,993,276	$1,993,276	$1,993,276	$1,993,276	$1,993,276	$1,993,276
License and Taxes	$10,305,261	$6,254,570	$7,503,116	$7,503,116	$7,503,116	$7,503,116	$7,503,116	$7,503,116
Interest	$5,362,099	$5,191,541	$5,005,099	$5,005,099	$5,005,099	$5,005,099	$5,005,099	$5,005,099
Other Direct Expenses	$942,709	$814,163	$2,216,844	$2,217,637	$2,220,276	$2,216,844	$2,216,844	$2,216,844
TOTAL OPERATING EXPENSES	$188,806,569	$191,131,282	$197,193,171	$197,438,445	$198,548,197	$199,598,713	$200,629,312	$201,551,218
NET OPERATING REVENUE	$2,758,078	$7,445,081	($1,319,952)	($540,012)	$1,762,014	$5,395,705	$9,236,464	$12,732,376
NON-OPERATING REVENUE-NET OF EXPENSES	$1,884,755	$936,562	$1,074,193	$887,366	$887,366	$887,366	$887,366	$887,366
NET REVENUE BEFORE ITEMS LISTED BELOW	$4,642,833	$8,381,644	($245,759)	$347,354	$2,649,380	$6,283,071	$10,123,830	$13,619,742
EXTRAORDINARY ITEM	$1,438,834	$755,734	$21,183	$0	$0	$0	$0	$0
FEDERAL INCOME TAX - UBI	$0	($150,000)	$29,000	$16,500	$16,500	$16,500	$16,500	$16,500
NET REVENUE OR (EXPENSE)	$3,203,999	$7,775,910	($295,942)	$330,854	$2,632,880	$6,266,571	$10,107,330	$13,603,242

HOSPITAL INFORMATION

BALANCE SHEET - UNRESTRICTED FUND-**HOSPITAL AGGREGATE WITH PROJECT**

ASSETS	Actual 2017	Actual 2018	Actual 2019	PROJECTED 2020	PROJECTED 2021	PROJECTED 2022	PROJECTED 2023	PROJECTED 2024
CURRENT ASSETS:								
Cash	$10,129,822	$7,901,858	$8,530,401	$8,538,620	$8,575,805	$8,611,005	$8,645,538	$8,676,429
Marketable Securities								
Accounts Receivable	$112,147,880	$112,645,276	$125,829,326	$126,446,601	$128,500,811	$131,324,085	$134,258,670	$136,920,036
Less-Estimated Uncollectable & Allowances	($89,534,292)	($91,256,017)	($101,993,930)	($102,494,277)	($104,159,365)	($106,447,836)	($108,826,534)	($110,983,767)
Receivables From Third Party Payors								
Pledges And Other Receivables	$1,367,757	$1,478,598	$1,493,287	$1,493,287	$1,493,287	$1,493,287	$1,493,287	$1,493,287
Due From Restricted Funds								
Inventory	$3,817,021	$4,047,252	$4,138,758	$4,138,758	$4,138,758	$4,138,758	$4,138,758	$4,138,758
Prepaid Expenses	$6,969	$0	$222,535	$222,535	$222,535	$222,535	$222,535	$222,535
Current Portion Of Funds Held In Trust								
TOTAL CURRENT ASSETS	**$37,935,158**	**$34,816,967**	**$38,220,377**	**$38,345,524**	**$38,771,831**	**$39,341,834**	**$39,932,255**	**$40,467,279**
BOARD DESIGNATED ASSETS:								
Cash								
Marketable Securities	$15,677,697	$20,752,117	$23,995,431	$38,393,963	$54,877,374	$74,845,022	$98,631,077	$125,957,877
Other Assets	$14,127,158	$15,182,601	$15,877,573	$15,877,573	$15,877,573	$15,877,573	$15,877,573	$15,877,573
TOTAL BOARD DESIGNATED ASSETS	**$29,804,854**	**$35,934,718**	**$39,873,004**	**$54,271,536**	**$70,754,946**	**$90,722,595**	**$114,508,649**	**$141,835,450**
PROPERTY, PLANT AND EQUIPMENT:								
Land	$7,487,010	$7,414,346	$7,414,346	$7,414,346	$7,414,346	$7,414,346	$7,414,346	$7,414,346
Land Improvements	$1,128,576	$1,128,574	$1,128,574	$1,128,574	$1,128,574	$1,128,574	$1,128,574	$1,128,574
Buildings	$123,227,161	$124,446,266	$124,817,616	$124,817,616	$124,817,616	$124,817,616	$124,817,616	$124,817,616
Fixed Equipment	$2,665,308	$2,258,058	$2,257,412	$2,257,412	$2,257,412	$2,257,412	$2,257,412	$2,257,412
Movable Equipment	$54,701,432	$63,938,836	$66,107,880	$66,107,880	$66,107,880	$66,107,880	$66,107,880	$66,107,880
Leasehold Improvements	$1,424	$1,424	$477,810	$477,810	$477,810	$477,810	$477,810	$477,810
Construction In Progress	$515,542	$3,193,954	$5,214,609	$5,214,609	$5,214,609	$5,214,609	$5,214,609	$5,214,609
TOTAL	**$189,746,452**	**$202,381,458**	**$207,418,247**	**$207,418,247**	**$207,418,247**	**$207,418,247**	**$207,418,247**	**$207,418,247**
Less Accumulated Depreciation	($39,611,051)	($53,250,572)	($67,419,561)	($81,588,550)	($95,757,539)	($109,926,528)	($124,095,517)	($138,264,506)
NET PROPERTY, PLANT & EQUIPMENT	**$150,135,401**	**$149,130,886**	**$139,998,686**	**$125,829,697**	**$111,660,707**	**$97,491,718**	**$83,322,729**	**$69,153,740**
INVESTMENTS AND OTHER ASSETS:								
Investments In Property, Plant & Equipment								
Less - Accumulated Depreciation								
Other Investments	$8,742,887	$9,628,161	$10,069,371	$10,069,371	$10,069,371	$10,069,371	$10,069,371	$10,069,371
Other Assets								
TOTAL INVESTMENTS & OTHER ASSETS	**$8,742,887**	**$9,628,161**	**$10,069,371**	**$10,069,371**	**$10,069,371**	**$10,069,371**	**$10,069,371**	**$10,069,371**
INTANGIBLES ASSETS:								
Goodwill								
Unamortized Loan Costs								
Preopening And Other Organization Costs								
Other Intangible Assets	$1,494,347	$1,494,347	$1,494,347	$1,494,347	$1,494,347	$1,494,347	$1,494,347	$1,494,347
TOTAL INTANGIBLE ASSETS	**$1,494,347**	**$1,494,347**	**$1,494,347**	**$1,494,347**	**$1,494,347**	**$1,494,347**	**$1,494,347**	**$1,494,347**
TOTAL ASSETS	**$228,112,647**	**$231,005,079**	**$229,655,784**	**$230,010,474**	**$232,751,202**	**$239,119,865**	**$249,327,351**	**$263,020,187**

HOSPITAL INFORMATION

BALANCE SHEET - UNRESTRICTED FUND-**HOSPITAL AGGREGATE WITH PROJECT**

LIABILITIES AND FUND BALANCES-UNRESTRICTED	Actual 2017	Actual 2018	Actual 2019	PROJECTED 2020	PROJECTED 2021	PROJECTED 2022	PROJECTED 2023	PROJECTED 2024
CURRENT LIABILITIES:								
Notes and Loans Payable								
Accounts Payable	$3,355,594	$4,499,978	$7,712,144	$7,721,737	$7,765,139	$7,806,224	$7,846,530	$7,882,585
Accrued Compensation and Related Liabilities	$7,449,977	$6,435,495	$6,248,453	$6,256,225	$6,291,390	$6,324,677	$6,357,334	$6,386,546
Other Accrued Expenses	$4,940,004	$5,843,672	$5,203,186	$5,209,658	$5,238,940	$5,266,659	$5,293,853	$5,318,178
Advances from Third Party Payors								
Payables to Third Party Payors	$16,658	$1,026,188	$1,295,551	$1,295,551	$1,295,551	$1,295,551	$1,295,551	$1,295,551
Due to Restricted Funds								
Income Taxes Payable								
Other Current Liabilities	$3,340	$65,904	$42,423	$42,423	$42,423	$42,423	$42,423	$42,423
Current Maturities of Long Term Debt	$3,855,576	$4,042,756	$4,239,024	$4,239,024	$4,239,024	$4,239,024	$4,239,024	$4,239,024
TOTAL CURRENT LIABILITIES	**$19,621,149**	**$21,913,992**	**$24,740,781**	**$24,764,617**	**$24,872,466**	**$24,974,558**	**$25,074,715**	**$25,164,308**
DEFERRED CREDITS:								
Deferred Income Taxes								
Deferred Third Party Revenue								
Other Deferred Credits								
TOTAL DEFERRED CREDITS	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
LONG TERM DEBT:								
Mortgage Payable								
Construction Loans - Interim Financing								
Operating Lease Obligations								
Capitalized Lease Obligations								
Bonds Payable								
Notes and Loans Payable to Parent	$107,185,132	$103,157,577	$98,934,493	$98,934,493	$98,934,493	$98,934,493	$98,934,493	$98,934,493
Noncurrent Liabilities	$2,774,758	$2,694,540	$2,792,410	$2,792,410	$2,792,410	$2,792,410	$2,792,410	$2,792,410
TOTAL	**$109,959,890**	**$105,852,117**	**$101,726,903**	**$101,726,903**	**$101,726,903**	**$101,726,903**	**$101,726,903**	**$101,726,903**
Less Current Maturities of Long Term Debt								
TOTAL LONG TERM DEBT	**$109,959,890**	**$105,852,117**	**$101,726,903**	**$101,726,903**	**$101,726,903**	**$101,726,903**	**$101,726,903**	**$101,726,903**
UNRESTRICTED FUND BALANCE	**$98,531,608**	**$103,238,970**	**$103,188,100**	**$103,518,954**	**$106,151,833**	**$112,418,404**	**$122,525,734**	**$136,128,976**
EQUITY (INVESTOR OWNED)								
Preferred Stock								
Common **Stock**								
Additional **Paid In Capital**								
Retained Earnings (Capital Account for Partnership or Sole Proprietorship)								
Less Treasury Stock								
TOTAL EQUITY	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
TOTAL LIABILITIES AND FUND BALANCE OR EQUITY	**$228,112,647**	**$231,005,079**	**$229,655,784**	**$230,010,474**	**$232,751,202**	**$239,119,865**	**$249,327,351**	**$263,020,187**

Hospital without the Project

HOSPITAL INFORMATION

DEDUCTIONS FROM REVENUE- HOSPITAL AGGREGATE WITHOUT THE PROJECT

		Actual	Actual	Actual	PROJECTED	PROJECTED	PROJECTED	PROJECTED	PROJECTED
ACCT:	ITEM:	2017	2018	2019	2020	2021	2022	2023	2024
5800	PROVISION FOR BAD DEBTS	$9,485,059	$7,052,593	$13,241,931	$13,241,931	$13,241,931	$13,241,931	$13,241,931	$13,241,931
	CONTRACTUAL ADJUSTMENTS								
5810	Medicare	$295,423,102	$322,734,946	$354,020,620	$354,020,620	$354,020,620	$354,020,620	$354,020,620	$354,020,620
5820	Medicaid	$191,352,348	$203,993,340	$198,724,020	$198,724,020	$198,724,020	$198,724,020	$198,724,020	$198,724,020
5830	Workers Compensation	$8,322,377	$8,358,545	$8,197,031	$8,197,031	$8,197,031	$8,197,031	$8,197,031	$8,197,031
5840	Other Government Programs	$8,588,769	$8,626,095	$8,459,411	$8,459,411	$8,459,411	$8,459,411	$8,459,411	$8,459,411
5850	Negotiated Rates	$134,676,104	$142,418,418	$159,944,402	$159,944,402	$159,944,402	$159,944,402	$159,944,402	$159,944,402
5860	Other	$36,424	$36,582	$35,875	$35,875	$35,875	$35,875	$35,875	$35,875
	Total Contractual Adjustments	**$638,399,124**	**$686,167,925**	**$729,381,359**	**$729,381,359**	**$729,381,359**	**$729,381,359**	**$729,381,359**	**$729,381,359**
	CHARITY CARE								
5900	Inpatient	$6,244,887	$9,442,296	$3,646,732	$3,646,732	$3,646,732	$3,646,732	$3,646,732	$3,646,732
5910	Outpatient	$11,179,771	$9,849,204	$11,487,662	$11,487,662	$11,487,662	$11,487,662	$11,487,662	$11,487,662
	Total Charity Care	$17,424,657	$19,291,500	$15,134,394	$15,134,394	$15,134,394	$15,134,394	$15,134,394	$15,134,394
5970	ADMINISTRATIVE ADJUSTMENTS	$10,242,415	$13,729,720	$13,756,743	$13,756,743	$13,756,743	$13,756,743	$13,756,743	$13,756,743
5980	OTHER DEDUCTIONS (Specify)	0		0	0	0	0	0	0
	TOTAL DEDUCTIONS FROM REVENUE	**$675,551,254**	**$726,241,738**	**$771,514,427**	**$771,514,427**	**$771,514,427**	**$771,514,427**	**$771,514,427**	**$771,514,427**

EXPLANATIONS:

HOSPITAL INFORMATION
COMPARISON STATEMENT OF REVENUE & EXPENSE-UNRESTRICTED
FUNDS-**HOSPITAL AGGREGATE WITHOUT PROJECT**

	Actual 2017	Actual 2018	Actual 2019	PROJECTED 2020	PROJECTED 2021	PROJECTED 2022	PROJECTED 2023	PROJECTED 2024
OPERATING REVENUE:								
Inpatient Revenue	$386,407,364	$422,375,540	$403,341,854	$403,341,854	$403,341,854	$403,341,854	$403,341,854	$403,341,854
Outpatient Revenue	$470,900,948	$491,987,676	$552,433,997	$552,433,997	$552,433,997	$552,433,997	$552,433,997	$552,433,997
TOTAL PATIENT SERVICES REVENUE	$857,308,312	$914,363,216	$955,775,851	$955,775,851	$955,775,851	$955,775,851	$955,775,851	$955,775,851
DEDUCTIONS FROM REVENUE:								
Provision for Bad Debt	$9,485,059	$7,052,593	$13,241,931	$13,241,931	$13,241,931	$13,241,931	$13,241,931	$13,241,931
Contractual Adjustments	$638,399,124	$686,167,925	$729,381,359	$729,381,359	$729,381,359	$729,381,359	$729,381,359	$729,381,359
Charity and Uncompensated Care	$17,424,657	$19,291,500	$15,134,394	$15,134,394	$15,134,394	$15,134,394	$15,134,394	$15,134,394
Other Adjustments and Allowances	$10,242,415	$13,729,720	$13,756,743	$13,756,743	$13,756,743	$13,756,743	$13,756,743	$13,756,743
TOTAL DEDUCTIONS FROM REVENUE	$675,551,254	$726,241,738	$771,514,427	$771,514,427	$771,514,427	$771,514,427	$771,514,427	$771,514,427
NET PATIENT SERVICE REVENUE	$181,757,057	$188,121,478	$184,261,424	$184,261,424	$184,261,424	$184,261,424	$184,261,424	$184,261,424
OTHER OPERATING REVENUE								
Other Operating Revenue	$9,807,589	$10,454,884	$11,611,795	$11,611,795	$11,611,795	$11,611,795	$11,611,795	$11,611,795
Tax Revenues	$0	$0	$0	$0	$0	$0	$0	$0
TOTAL OTHER OPERATING REVENUE	$9,807,589	$10,454,884	$11,611,795	$11,611,795	$11,611,795	$11,611,795	$11,611,795	$11,611,795
TOTAL OPERATING REVENUE	$191,564,646	$198,576,363	$195,873,219	$195,873,219	$195,873,219	$195,873,219	$195,873,219	$195,873,219
OPERATING EXPENSES								
Salaries and Wages	$64,431,369	$62,240,065	$61,103,851	$61,103,851	$61,103,851	$61,103,851	$61,103,851	$61,103,851
Employee Benefits	$18,195,846	$17,375,839	$16,407,182	$16,407,182	$16,407,182	$16,407,182	$16,407,182	$16,407,182
Professional Fees	$6,455,605	$8,428,669	$9,287,563	$9,287,563	$9,287,563	$9,287,563	$9,287,563	$9,287,563
Supplies	$24,537,203	$24,034,251	$24,310,875	$24,310,875	$24,310,875	$24,310,875	$24,310,875	$24,310,875
Purchased Services - Utilities	$1,687,802	$1,625,454	$1,672,287	$1,672,287	$1,672,287	$1,672,287	$1,672,287	$1,672,287
Purchased Services - Other	$39,940,437	$46,371,880	$50,411,238	$50,411,238	$50,411,238	$50,411,238	$50,411,238	$50,411,238
Depreciation	$12,049,316	$13,934,082	$14,244,947	$14,244,947	$14,244,947	$14,244,947	$14,244,947	$14,244,947
Rentals and Leases	$2,278,864	$1,962,105	$1,675,676	$1,675,676	$1,675,676	$1,675,676	$1,675,676	$1,675,676
Repairs and Maintenance	$742,871	$1,085,757	$1,361,217	$1,361,217	$1,361,217	$1,361,217	$1,361,217	$1,361,217
Insurance	$1,877,187	$1,812,907	$1,993,276	$1,993,276	$1,993,276	$1,993,276	$1,993,276	$1,993,276
License and Taxes	$10,305,261	$6,254,570	$7,503,116	$7,503,116	$7,503,116	$7,503,116	$7,503,116	$7,503,116
Interest	$5,362,099	$5,191,541	$5,005,099	$5,005,099	$5,005,099	$5,005,099	$5,005,099	$5,005,099
Other Direct Expenses	$942,709	$814,163	$2,216,844	$2,216,844	$2,216,844	$2,216,844	$2,216,844	$2,216,844
TOTAL OPERATING EXPENSES	**$188,806,569**	**$191,131,282**	**$197,193,171**	**$197,193,171**	**$197,193,171**	**$197,193,171**	**$197,193,171**	**$197,193,171**
NET OPERATING REVENUE	**$2,758,078**	**$7,445,081**	**($1,319,952)**	**($1,319,952)**	**($1,319,952)**	**($1,319,952)**	**($1,319,952)**	**($1,319,952)**
NON-OPERATING REVENUE-NET OF EXPENSES	$1,884,755	$936,562	$1,074,193	$1,074,193	$1,074,193	$1,074,193	$1,074,193	$1,074,193
NET REVENUE BEFORE ITEMS LISTED BELOW	**$4,642,833**	**$8,381,644**	**($245,759)**	**($245,759)**	**($245,759)**	**($245,759)**	**($245,759)**	**($245,759)**
EXTRAORDINARY ITEM	$1,438,834	$755,734	$21,183	$0	$0	$0	$0	$0
FEDERAL INCOME TAX - UBI	$0	($150,000)	$29,000	$29,000	$29,000	$29,000	$29,000	$29,000
NET REVENUE OR (EXPENSE)	**$3,203,999**	**$7,775,910**	**($295,942)**	**($274,759)**	**($274,759)**	**($274,759)**	**($274,759)**	**($274,759)**

EXPLANATION:

HOSPITAL INFORMATION

BALANCE SHEET - UNRESTRICTED FUND-HOSPITAL AGGREGATE WITHOUT

ASSETS	Actual 2017	Actual 2018	Actual 2019	PROJECTED 2020	PROJECTED 2021	PROJECTED 2022	PROJECTED 2023	PROJECTED 2024
CURRENT ASSETS:								
Cash	$10,129,822	$7,901,858	$8,530,401	$8,530,401	$8,530,401	$8,530,401	$8,530,401	$8,530,401
Marketable Securities								
Accounts Receivable	$112,147,880	$112,645,276	$125,829,326	$125,829,326	$125,829,326	$125,829,326	$125,829,326	$125,829,326
Less-Estimated Uncollectable & Allowances	($89,534,292)	($91,256,017)	($101,993,930)	($101,993,930)	($101,993,930)	($101,993,930)	($101,993,930)	($101,993,930)
Receivables From Third Party Payors								
Pledges And Other Receivables	$1,367,757	$1,478,598	$1,493,287	$1,493,287	$1,493,287	$1,493,287	$1,493,287	$1,493,287
Due From Restricted Funds								
Inventory	$3,817,021	$4,047,252	$4,138,758	$4,138,758	$4,138,758	$4,138,758	$4,138,758	$4,138,758
Prepaid Expenses	$6,969	$0	$222,535	$222,535	$222,535	$222,535	$222,535	$222,535
Current Portion Of Funds Held In Trust								
TOTAL CURRENT ASSETS	**$37,935,158**	**$34,816,967**	**$38,220,377**	**$38,220,377**	**$38,220,377**	**$38,220,377**	**$38,220,377**	**$38,220,377**
BOARD DESIGNATED ASSETS:								
Cash								
Marketable Securities	$15,677,697	$20,752,117	$23,995,431	$23,995,431	$23,995,431	$23,995,431	$23,995,431	$23,995,431
Other Assets	$14,127,158	$15,182,601	$15,877,573	$15,877,573	$15,877,573	$15,877,573	$15,877,573	$15,877,573
TOTAL BOARD DESIGNATED ASSETS	**$29,804,854**	**$35,934,718**	**$39,873,004**	**$39,873,004**	**$39,873,004**	**$39,873,004**	**$39,873,004**	**$39,873,004**
PROPERTY, PLANT AND EQUIPMENT:								
Land	$7,487,010	$7,414,346	$7,414,346	$7,414,346	$7,414,346	$7,414,346	$7,414,346	$7,414,346
Land Improvements	$1,128,576	$1,128,574	$1,128,574	$1,128,574	$1,128,574	$1,128,574	$1,128,574	$1,128,574
Buildings	$123,227,161	$124,446,266	$124,817,616	$124,817,616	$124,817,616	$124,817,616	$124,817,616	$124,817,616
Fixed Equipment	$2,685,308	$2,258,058	$2,257,412	$2,257,412	$2,257,412	$2,257,412	$2,257,412	$2,257,412
Movable Equipment	$54,701,432	$63,938,836	$66,107,880	$66,107,880	$66,107,880	$66,107,880	$66,107,880	$66,107,880
Leasehold Improvements	$1,424	$1,424	$477,810	$477,810	$477,810	$477,810	$477,810	$477,810
Construction In Progress	$515,542	$3,193,954	$5,214,609	$5,214,609	$5,214,609	$5,214,609	$5,214,609	$5,214,609
TOTAL	**$189,746,452**	**$202,381,458**	**$207,418,247**	**$207,418,247**	**$207,418,247**	**$207,418,247**	**$207,418,247**	**$207,418,247**
Less Accumulated Depreciation	($39,611,051)	($53,250,572)	($67,419,561)	($67,419,561)	($67,419,561)	($67,419,561)	($67,419,561)	($67,419,561)
NET PROPERTY, PLANT & EQUIPMENT	**$150,135,401**	**$149,130,886**	**$139,998,686**	**$139,998,686**	**$139,998,686**	**$139,998,686**	**$139,998,686**	**$139,998,686**
INVESTMENTS AND OTHER ASSETS:								
Investments In Property, Plant & Equipment								
Less - Accumulated Depreciation								
Other Investments	$8,742,887	$9,628,161	$10,069,371	$10,069,371	$10,069,371	$10,069,371	$10,069,371	$10,069,371
Other Assets								
TOTAL INVESTMENTS & OTHER ASSETS	**$8,742,887**	**$9,628,161**	**$10,069,371**	**$10,069,371**	**$10,069,371**	**$10,069,371**	**$10,069,371**	**$10,069,371**
INTANGIBLES ASSETS:								
Goodwill								
Unamortized Loan Costs								
Preopening And Other Organization Costs								
Other Intangible Assets	$1,494,347	$1,494,347	$1,494,347	$1,494,347	$1,494,347	$1,494,347	$1,494,347	$1,494,347
TOTAL INTANGIBLE ASSETS	**$1,494,347**	**$1,494,347**	**$1,494,347**	**$1,494,347**	**$1,494,347**	**$1,494,347**	**$1,494,347**	**$1,494,347**
TOTAL ASSETS	**$228,112,647**	**$231,005,079**	**$229,655,784**	**$229,655,784**	**$229,655,784**	**$229,655,784**	**$229,655,784**	**$229,655,784**

HOSPITAL INFORMATION

BALANCE SHEET - UNRESTRICTED FUND-HOSPITAL AGGREGATE WITHOUT

	Actual	Actual	Actual	PROJECTED	PROJECTED	PROJECTED	PROJECTED	PROJECTED
LIABILITIES AND FUND BALANCES-UNRESTRICTED	2017	2018	2019	2020	2021	2022	2023	2024
CURRENT LIABILITIES:								
Notes and Loans Payable								
Accounts Payable	$3,355,594	$4,499,978	$7,712,144	$7,712,144	$7,712,144	$7,712,144	$7,712,144	$7,712,144
Accrued Compensation and Related Liabilities	$7,449,977	$6,435,495	$6,248,453	$6,248,453	$6,248,453	$6,248,453	$6,248,453	$6,248,453
Other Accrued Expenses	$4,940,004	$5,843,672	$5,203,186	$5,203,186	$5,203,186	$5,203,186	$5,203,186	$5,203,186
Advances from Third Party Payors								
Payables to Third Party Payors	$16,658	$1,026,188	$1,295,551	$1,295,551	$1,295,551	$1,295,551	$1,295,551	$1,295,551
Due to Restricted Funds								
Income Taxes Payable								
Other Current Liabilities	$3,340	$65,904	$42,423	$42,423	$42,423	$42,423	$42,423	$42,423
Current Maturities of Long Term Debt	$3,855,576	$4,042,756	$4,239,024	$4,239,024	$4,239,024	$4,239,024	$4,239,024	$4,239,024
TOTAL CURRENT LIABILITIES	**$19,621,149**	**$21,913,992**	**$24,740,781**	**$24,740,781**	**$24,740,781**	**$24,740,781**	**$24,740,781**	**$24,740,781**
DEFERRED CREDITS:								
Deferred Income Taxes								
Deferred Third Party Revenue								
Other Deferred Credits								
TOTAL DEFERRED CREDITS	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
LONG TERM DEBT:								
Mortgage Payable								
Construction Loans - Interim Financing								
Operating Lease Obligations	$0	$0	$0	$0	$0	$0	$0	$0
Capitalized Lease Obligations								
Bonds Payable								
Notes and Loans Payable to Parent	$107,185,132	$103,157,577	$98,934,493	$98,934,493	$98,934,493	$98,934,493	$98,934,493	$98,934,493
Noncurrent Liabilities	$2,774,758	$2,694,540	$2,792,410	$2,792,410	$2,792,410	$2,792,410	$2,792,410	$2,792,410
TOTAL	**$109,959,890**	**$105,852,117**	**$101,726,903**	**$101,726,903**	**$101,726,903**	**$101,726,903**	**$101,726,903**	**$101,726,903**
Less Current Maturities of Long Term Debt								
TOTAL LONG TERM DEBT	**$109,959,890**	**$105,852,117**	**$101,726,903**	**$101,726,903**	**$101,726,903**	**$101,726,903**	**$101,726,903**	**$101,726,903**
UNRESTRICTED FUND BALANCE	**$98,531,608**	**$103,238,970**	**$103,188,100**	**$103,188,100**	**$103,188,100**	**$103,188,100**	**$103,188,100**	**$103,188,100**
EQUITY (INVESTOR OWNED)								
Preferred Stock								
Common Stock								
Additional Paid In Capital								
Retained Earnings (Capital Account for Partnership or Sole Proprietorship)								
Less Treasury Stock								
TOTAL EQUITY	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
TOTAL LIABILITIES AND FUND BALANCE OR EQUITY	**$228,112,647**	**$231,005,079**	**$229,655,784**	**$229,655,784**	**$229,655,784**	**$229,655,784**	**$229,655,784**	**$229,655,784**

Exhibit 6
Patient Origin

Zip	% of Total
98168	14.3%
98198	13.9%
98166	11.1%
98146	10.2%
98188	8.3%
98148	6.2%
98106	4.0%
98032	2.6%
98003	2.0%
98126	2.0%
98070	1.3%
98023	1.2%
98116	1.1%
98108	1.1%
98136	1.1%
98001	0.8%
98031	0.8%
98178	0.8%
98118	0.7%
98002	0.6%
98030	0.6%
98104	0.5%
98058	0.4%
98057	0.4%
98391	0.4%
98042	0.3%
98056	0.3%
98092	0.3%
98055	0.3%
98499	0.3%
98022	0.3%
98122	0.2%
98062	0.2%
Other	11.1%
Total	**100.0%**

Exhibit 7
Policies

All Policies Site - CHI Franciscan Health System

Origination:	*06/1996*
Effective:	*06/2018*
Last Approved:	*06/2018*
Last Revised:	*06/2018*
Next Review:	*06/2021*
Owner:	*Kathryn McKee: Division Director Accreditation/Safety*
Policy Area:	*General Governance*
References:	*Administrative*
Applicability:	*CHI Franciscan System + FMG*

Nondiscrimination Policy, 350.00

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POLICY

As a recipient of Federal financial assistance, CHI Franciscan Health (CHI Franciscan) is dedicated to providing services to patients and welcoming visitors in a manner that respects, protects, and promotes patient rights. CHI Franciscan does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of age, race, color, creed, national origin, ethnicity, religion, marital status, sex, sexual orientation, gender identity or expression, physical , mental or other disability, citizenship, medical condition, or any other basis prohibited by federal, state, or local law in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by CHI Franciscan directly or through a contractor or any other entity with which CHI Franciscan arranges to carry out its programs and activities.

SUPPORTIVE DATA:

- Service Animals #104.50
- Patient Rights/Responsibilities Policy #390.00
- Grievance Policy #320.00
- Interpreter Services/Communication Aid Policy #721.50
- Interpreter services https://chifh.catholichealth.net/Comm/is/Pages/default.aspx

PROCEDURE

State and federal laws and CHI Franciscan policy prohibit retaliation in any form against any person who has filed a discrimination complaint or assisted in the investigation of a discrimination complaint.

A. **Notice of Program Accessibility**
   In compliance with Section 504 of regulation 45 C.F.R. 84.22(f) and Section 1557 of regulation 45 C.F.R.92., CHI Franciscan has implemented procedures to ensure that interested persons, including those with impaired vision or hearing can obtain information as to the existence and location of services, activities, and facilities that are accessible to and usable by disabled persons.
   CHI Franciscan facilities and all its programs and activities are accessible to and useable by individuals with limited English proficiency (LEP) and by individuals with disabilities, including those who are deaf, hard of hearing, or blind, or who have other sensory impairments. Access features include, but are not limited to:

   - Convenient off-street parking designated for disabled persons
   - Curb cuts and ramps between parking areas and buildings

- Level access into first floor level with elevator access to all other floors; automatic doors
- Fully accessible offices , meeting rooms, bathrooms, public waiting rooms, cafeteria, patient treatment areas including examination and patient rooms.
- A range of assistive devices and communication aids available to persons who are deaf, hard of hearing, or blind, or have other sensory impairments. There is no additional charge for such aids.
- Qualified sign language interpreters for persons who are deaf or hard of hearing
- A 24 hour telecommunication device (TTY/TDD), which can connect the caller to all extensions within the facility and/or portable (TTY/TTD) units, for use by individuals who are deaf, hard of hearing or speech impaired.
- Communication boards/note pads
- Assistive devices for person with impaired manual skills
- Qualified language interpreters for persons with LEP
  Each facility/program is required to identify the aids available within their internal procedures. Any patient requiring an available aid should inform the admitting staff of his/her special need(s). CHI Franciscan will provide notice during registration of services available at no charge.

B. **Auxiliary Aids and Services for Individuals with Disabilities**
CHI Franciscan will take appropriate steps to ensure that individuals with LEP and individuals with disabilities, including those who are deaf, hard of hearing, or blind or who have other sensory or manual impairments, have an equal opportunity to participate in our services, activities, programs and other benefits. The procedures are intended to ensure effective communication with patients involving their medical conditions, treatments, services and benefits. The procedures also apply to, at minimum, communication of information contained in important documents, including consent to treatment forms, conditions of admission forms, and financial and insurance benefits forms. All necessary auxiliary aids and services shall be provided without cost to the individual(s) being served.
CHI Franciscan will provide written notice of these patient rights during registration. Refer to Patient Rights/Responsibilities Policy. Staff that may have direct contact with individuals with LEP and individuals with disabilities will be trained in effective communication techniques, including the effective use and access to interpreters, aids, and services.
Procedures:

1. **Identification and Assessment of Need(s)**
   CHI Franciscan will provide notice of the availability of, contact information, and the procedure for requesting auxiliary aids and services, through notices posted, at minimum in main facility entrances, emergency entrances, and patient care registration entrances. When individuals self-identify as a person with LEP or with a disability that affects the ability to communicate or to access or manipulate written materials, or requests an auxiliary aid or service, staff will consult with the individual to determine what aids or services are necessary to provide effective communication in specific situations. Inpatients are screened on admission for barriers to communication.
2. **Provision of Auxiliary Aids and Services**
   CHI Franciscan shall provide the following services or aids to achieve effective communication with individuals with disabilities:
   a. **For Persons Who Are Deaf or Hard of Hearing (Hearing Impaired)**
      - For persons who are deaf/hard of hearing and who use sign language as their primary means of communication, the facility/program staff handling intake/registration or the

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clinician as appropriate, is responsible for arranging for a qualified interpreter when needed. Refer to Policy #721.50 Interpreter Services/Communication Aid Policy

- Communicating by Telephone with Persons Who Are Deaf or Hard of Hearing. CHI Franciscan utilizes a 24 hour telecommunication device for deaf persons (TDDs) and relay services for external telephone with TTY users. We accept and make calls through a relay service.
- Other possible methods of communication may include, but are not limited to: Note-takers; computer-aided transcription services; telephone handset amplifiers; written copies of oral announcements; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning; telecommunications devices for deaf persons (TDDs); videotext displays; or other effective methods that help make aurally delivered materials available to individuals who are deaf or hard of hearing.
- Some persons who are deaf or hard of hearing may prefer or request to use a family member or friend as an interpreter. Family members or friends of the person will not be used as interpreters unless specifically requested by that individual, and after an offer of an interpreter at no charge to the person has been made by the facility. **Such an offer and the response will be documented in the person's medical record**. If the person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy, and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services will be provided.
- NOTE: Children will not be used to interpret, in order to ensure confidentiality of information and accurate communication.

b. **For Persons Who are Blind or Who Have Low Vision**

- Staff will communicate information contained in written materials concerning treatment, benefits, services, waivers of rights, and consent to treatment forms by reading out loud and explaining these forms to persons who are blind or who have low vision.
- Other possible methods of communication may include, but are not limited to: qualified readers; reformatting into large print; taping or recording of print materials not available in alternate format; or other effective methods that help make visually delivered materials available to individuals who are blind or who have low vision. In addition, staff are available to assist persons who are blind or who have low vision in filling out forms and in otherwise providing information in a written format.

c. **For Persons With Speech Impairments**

- To ensure effective communication with persons with speech impairments, staff may utilize written materials; TDDs; computers; flashcards; alphabet boards; and other communication aids.

d. **For Persons With Manual Impairments**

- Staff will assist those who have difficulty in manipulating print materials by holding the materials and turning pages as needed, or by providing one or more of the following:
- Note-takers; computer-aided transcription services; speaker phones; or other effective methods that help to ensure effective communication by individuals with manual

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impairments.

e. **Communication with Persons with LEP-**

- CHI Franciscan will take reasonable steps to ensure that persons with LEP have meaningful access and an equal opportunity to participate in our services, activities, programs and other benefits. The policy of CHI Franciscan is to ensure that each of its facilities, services and programs provides meaningful communication with LEP patients/clients and their authorized representatives involving their medical conditions and treatment. The policy also provides for communication of information contained in vital documents, including but not limited to, waivers of rights, consent to treatment forms, financial and insurance benefit forms, etc. Interpreters, translators and other aids needed to comply with this policy shall be provided without cost to the person being served. Patients/clients and their families will be informed of the availability of free of charge assistance at point of facility or program access.
- Language assistance will be provided at each of the CHI Franciscan facilities/programs, and may include use of competent bilingual staff, staff interpreters, contracts or formal arrangements with local organizations and state agencies providing interpretation or translation services, or technology and telephonic interpretation services. Each facility and program is responsible for defining the language assistance methods available to patients and clients and are responsible for ensuring staff is provided notice of its internal policies and procedures. Staff that may have direct contact with LEP individuals will be trained in effective communication techniques, including the effective use of an interpreter.
- CHI Franciscan will conduct a regular review of the language access needs of our patient population, as well as update and monitor the implementation of and adherence to this policy within the organization.
- Maintain an accurate and current listing of outside interpreter services who have agreed to provide qualified interpreter services for facility/program patients. See Language Interpreter Services Form. These listings may be obtained on the CHI Franciscan intranet/departments/interpretive services, or Interpreter Services/Comminication Aid Policy #721.50. Some LEP persons may prefer or request to use a family member or friend as an interpreter. Family members or friends of the LEP person will not be used as interpreters unless specifically requested by that individual and **after** the LEP person has understood that an offer of an interpreter, at no charge to the person, has been made by the facility. Such an offer and the response will be documented in the person's file. If the LEP person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy, and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services will be provided to the LEP person.
  Children and other clients/patients will **not** be used to interpret, in order to ensure confidentiality of information and accurate communication.
- **Providing Notice to LEP Persons**
  Each facility or program will post notices and signs in languages LEP persons understand informing them of the availability of language assistance, free of charge. At a minimum, notices and signs will be posted and provided in intake areas and other points of entry, including but not limited to main admitting, the emergency room and outpatient areas.
  Refer to Addendum A: Notice of Interpreter Services

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- **Monitoring Language Needs and Implementation**
  CHI Franciscan will periodically assess changes in demographics, types of services or other needs that may require reevaluation of the LEP policy and its supporting procedures. The efficacy of the procedures will be regularly assessed. The assessment is inclusive of, but not limited to, mechanisms for securing interpreter services, equipment used for the delivery of language assistance, complaints filed by LEP persons, feedback from patients, staff, and community organizations. Each facility or program within CHI Franciscan will set benchmarks for translation of vital documents into additional languages over time.

- Refer to Interpreter Services/Commincation Aid Policy #721.50

C. **Regional and Hospital Section 504 and Section 1557 Coordination**
CHI Franciscan facility administration designates a Section 504 and Section 1557 Coordinator for each hospital who is responsible for assuring compliance oversight for non-discrimination requirements. This includes maintenance of an accurate and current list of the contacts, compliance with current policies/standards, relevant staff training, and signage/communication compliance. The Emergency Department Patient Access representative is designated for each CHI Franciscan facility to serve as the local point of contact for language services and aids. The Patient Advocate is responsible for an effective grievance process relating to nondiscrimination issues and can be contacted at 1-877-426-4701 or via mail to the hospital's administration office. .

D. **Section 504/Section 1557 Grievance Procedure**
All CHI Franciscan facilities/programs have an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any discrimination. Any person who believes she or he has been subjected to discrimination on the basis of disability may file a grievance under this procedure.
Procedure:

- Grievances must be submitted to the patient advocate or designee within 30 days of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- Grievances may be confidentially submitted to the patient advocate or designee in writing or by calling the CHI Franciscan Concern Line and must include the name and address of the person filing the grievance. The grievance must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The patient advocate or designee will coordinate an investigation of the grievance. This investigation must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The patient advocate or designee will retain grievance investigation findings, files, and records for CHI Franciscan facilities/programs.
- The patient advocate or designee will issue a written decision on the grievance no later than 30 days after its filing.
- The person filing the grievance may appeal the grievance decision with the patient advocate supervisor by writing to the hospital administration office within 15 days of receiving the grievance letter of response.
- The patient advocate supervisor will issue a written decision in response to the appeal no later than 30 days after its filing.
- The availability of each a facility or program grievance procedure does not prevent a person from filing a complaint of discrimination on the basis of disability with the US Department of Health and Human Services, Office for Civil Rights.

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The patient advocate will make appropriate arrangements to ensure that disabled persons are provided other accommodations if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing interpreters for the deaf, providing taped cassettes of material for the blind, or assuring a barrier-free location for the proceedings. The patient advocate or designee will be responsible for such arrangements.

Any patient who believes she or he has been subjected to discrimination on the basis of disability may file a grievance under the hospital grievance policy and has the right to file a civil rights complaint with the U.S. Department of health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, and at:

U.S. Department of health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

E. **Accessibility/Signage**
The hospital will maintain in operable working condition those features of facilities and equipment that are required to be readily accessible to and usable by individuals with disabilities. Problems with such equipment should be reported immediately to the site Patient Access Services.

REFERENCES

COPY

- Title VI of the Civil Rights Act of 1964
- Section 504 of the Rehabilitation Act of 1973
- Age Discrimination Act of 1975
- Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 code of Federal Regulations Parts 80, 84, and 91
- Ethical and Religious Directives for Catholic Health Services
- Section 1557 of the Affordable Care Act

REQUIRED REVIEW:

RISK, PATIENT ACCESS, LEGAL, REGULATORY

Attachments

No Attachments

Approval Signatures

Approver	Date
Michele Avery: administrative coordinator	06/2018
Julie Burns: FHS Accreditation/Safety	06/2018

Approver	Date
Laurie Brown: CNO	06/2018

Applicability

CHI Franciscan Health, Franciscan Medical Group, Harrison Medical Center, Highline Medical Center, St. Anthony Hospital, St. Clare Hospital, St. Elizabeth Hospital, St. Francis Hospital, St. Joseph Medical Center

Current Status: *Active*		**PolicyStat ID:** *5072090*
All Policies Site - CHI Franciscan Health System	**Origination:**	*03/2014*
	Effective:	*07/2018*
	Last Approved:	*07/2018*
	Last Revised:	*07/2018*
	Next Review:	*07/2021*
	Owner:	*Rose Shandrow: Div Director Mission*
	Policy Area:	*Corporate Ethics/Privacy*
	References:	
	Applicability:	*CHI Franciscan Systemwide*

Reproductive Healthcare, 392.00

PURPOSE

Provide general guidance in the area of reproductive health care.

POLICY

Formulation of policy and practice are consistent with the Franciscan Health System mission to protect human life and respect human dignity.

It is the policy of Franciscan Health System that all services rendered in our hospitals shall be supportive of life. At no time may direct actions to terminate life be performed or permitted.

Medical Staff, staff, and family/surrogate decision-makers may consult with the CHI FH Ethics Committee to advise on policy for decision-making where ethical considerations involving reproductive health care might need additional guidance. See: **Initiating Ethics Consult Policy, #370.00.**

For hospitals with Emergency Departments: Franciscan Health System supports the hospital's obligations under WAC 246-320-370 for emergency contraception provisions for sexual assault victims. The Emergency Department (ED) must provide emergency contraception as a treatment option to any woman who seeks treatment as a result of a sexual assault. The Emergency Department provider must provide each patient with medically and factually accurate and unbiased written and oral information about emergency contraception. Refer to: **Sexual Assault Victims Emergency Contraception Options Policy, #826.75**

REQUIRED REVIEW:

Senior Vice President of Mission

DISTRIBUTION:

Regional Administrative Manual

CROSS REFERENCE:

Attachments

No Attachments

COPY

Approval Signatures

Approver	Date
Michele Avery: administrative coordinator	07/2018
Julie Burns: FHS Accreditation/Safety	07/2018
Holly Stroud: VP CRP	07/2018
Rose Shandrow: Div Director Mission	07/2018

Applicability

CHI Franciscan Health, Harrison Medical Center, Highline Medical Center, St. Anthony Hospital, St. Clare Hospital, St. Elizabeth Hospital, St. Francis Hospital, St. Joseph Medical Center

COPY

Current Status: *Active*		PolicyStat ID: *4899292*
All Policies Site - CHI Franciscan Health System	Origination:	*06/1996*
	Effective:	*05/2018*
	Last Approved:	*05/2018*
	Last Revised:	*05/2018*
	Next Review:	*05/2021*
	Owner:	*Kathryn McKee: Division Director Accreditation/Safety*
	Policy Area:	*Patient Rights/Ethics*
	References:	*Administrative*
	Applicability:	*CHI Franciscan Systemwide*

Notice of Patients Rights and Responsibilities on Admission, 390.00

PURPOSE

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

POLICY

COPY

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

SUPPORTIVE DATA

- Patient Rights/Responsibilities, Standards/Acknowledgement form, Addendum A
- Notice of Interpreter Services, Addendum B
- ***Grievance Policy***
- ***Nondiscrimination Policy***
- ***Patient Visitation Policy***
- ***Consent for Treatment Policy***
- 42 CFR 482.13 Conditions of Participation: Patient's Rights
- Joint Commission Standards, Current Edition
- Americans with Disabilities (ADA)
- Ethical/Religious Directives for Catholic Health Care

PROCEDURE

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

Series Patients

Outpatients in certain therapeutic programs involving ongoing courses of treatments or therapies may sign an

acknowledgement for an entire course of therapy or treatment prior to the first treatment, and a single form may be signed for the entire course of treatment or therapy if:

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

SIGNAGE

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

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

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

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RESPONSIBILITY

Patient Access/Registration staff is responsible for providing the patient/legal representative with the site specific "Patient Rights/Responsibilities – Notice and Acknowledgment" form. The patient/legal representative is asked to read, acknowledge and sign that he/she has received the information.

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

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

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

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

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

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

PATIENT RIGHTS

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

- Be fully informed of all your patient rights and receive a written copy, in advance of furnishing or discontinuing care whenever possible.
- Not be discriminated against because of your race, beliefs, age, ethnicity, religion, culture, language, social, physical or mental disability, socio-economic status, sex, sexual orientation, gender identity or expression.
- To be accompanied by a trained service animal or dog guide.
- Be treated with dignity and respect including cultural and personal beliefs, values and preferences.
- Confidentiality, reasonable personal privacy, security, safety, spiritual or religious care accommodations, and communication. If communication restrictions are necessary for patient care and safety, the hospital must document and explain the restrictions to the patient and family.
- Be protected from neglect; exploitation; verbal, mental, physical or sexual abuse; Access to protective and advocacy services.
- Receive information about your condition including unanticipated outcomes, agree and be involved in all aspects and decisions of their care including: refusing care, treatment and services to the extent permitted by law and to be informed of the consequences of your actions; and resolving problems with care decisions; the hospital will involve the surrogate decision-maker when the patient is unable to make decisions about his or her care.
- Receive information in a manner tailored to the patient's age, language needs and ability to understand. An interpreter, translator or other auxiliary aids, tools or services will be provided to you for vital and necessary information free of charge.
- Make informed decisions regarding care including options, alternatives, risk and benefits. The hospital honors your right to give, rescind and withhold consent.
- Receive an appropriate medical screening examination or treatment for an emergency medical condition within the capabilities of the hospital, regardless of your ability to pay for such services.
- Have a family member or representative of your choice and your physician notified.
- Know the individual(s) responsible for, as well as those providing, your care, treatment and services.
- Family or representatives notification of your admission and input in care decisions; designate any individual to be present for emotional support during course of stay.
- An appropriate assessment and management of your pain.
- Be free from restraints and seclusion of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.
- Have advance directives and for hospitals to respect and follow those directives; The hospital honors

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advance directives, in accordance with law and regulation and the hospital's capabilities, religious directives and policies.
- End of life care; Request no resuscitation or life-sustaining treatment.
- Donate organs and other tissues including medical staff input and direction by family or surrogate decision makers.
- Review, request amendment to and obtain information on disclosures of your health information in accordance with law and regulation.
- File a grievance (complaint) and to be informed of the process to review and resolve the grievance without fear of retribution or denial of care. The grievance process and relevant contact information is spelled out in the notice provided to each patient and/or leg representative.

PATIENT RESPONSIBILITIES

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

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

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GRIEVANCE PROCESS

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

SERVICE ANIMALS

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

PATIENT VISITATION RIGHTS

Patients of Franciscan Health System enjoy visitation privileges consistent with the patient preference and subject to the hospital's Justified Clinical Restrictions. Each patient has the right to receive the visitors whom he/ she designates and may designate a support person to exercise the patient's visitation rights on his/ her

behalf. All visitors designated by the patient (or support person where appropriate) shall enjoy visitation privileges that are no more restrictive than those that immediate family member would enjoy. The designation of a support person does not extend to the medical decision making.

The hospital may impose clinically necessary or reasonable restrictions or limitations on patient visitation when necessary to respect all other patient rights and to provide safe care to patients. A justified Clinical Restriction may include, but need not be limited to one or more of the following: (i) a court order limiting or restraining contact; (ii) behavior presenting a direct risk or threat to the patient, hospital staff, or others in the immediate environment; (iii) behavior disruptive of the functioning of the patient care unit; (iv) reasonable limitations on the number of visitors at any one time; (v) patient's risk of infection by the visitor; (vi) visitor's risk of infection by the patient; (vii) extraordinary protections because of a pandemic or infectious disease outbreak; (viii) substance abuse treatment protocols requiring restricted visitation; (ix) patient's need for privacy or rest; (x) need for privacy or rest by another individual in the patient's shared room; or (xi) when the patient is undergoing clinical intervention or procedure and the treating health care professional believes it is in the patient's best interest to limit visitation during the clinical intervention or procedure.

REQUIRED REVIEW:

Ethics Committee, Regulatory, Risk, Patient Access

DISTRIBUTION:

Regional Administrative Manual

CROSS REFERENCE:

COPY

Attachments

596491 Patient Rights Responsibilities Notice 2017.pdf
Addendum A: Patient Rights/Responsibilities/Standards/Acknowledgement
Addendum B: Notice of Interpreter Services

Approval Signatures

Approver	Date
Michele Avery: administrative coordinator	05/2018
Julie Burns: FHS Accreditation/Safety	05/2018
Julie Burns: FHS Accreditation/Safety	05/2018

Applicability

CHI Franciscan Health, Harrison Medical Center, Highline Medical Center, St. Anthony Hospital, St. Clare

Hospital, St. Elizabeth Hospital, St. Francis Hospital, St. Joseph Medical Center

COPY

POLICY SUBJECT:
Financial Assistance

EFFECTIVE DATE: 03/14/12
To be reviewed every three years by the Board of Stewardship Trustees

REVIEW BY: 12/07/19

POLICY

It is the policy of Catholic Health Initiatives (CHI), and each of its tax-exempt Direct Affiliates[1] and tax-exempt Subsidiaries[2] that Operates a Hospital Facility [collectively referred to as CHI Hospital Organization(s)], to provide, without discrimination, Emergency and other Medically Necessary Care (herein referred to as EMCare) in CHI Hospital Facilities to all patients, without regard to a patient's financial ability to pay.

PRINCIPLES

As Catholic health care providers and tax-exempt organizations, CHI Hospital Organization(s) are called to meet the needs of patients and others who seek care, regardless of their financial abilities to pay for services provided.

The following principles are consistent with CHI's mission to deliver compassionate, high-quality, affordable healthcare services and to advocate for those who are poor and vulnerable. CHI Hospital Organizations strive to ensure that the financial ability of people who need health care services does not prevent them from seeking or receiving care.

Emergency Care - CHI Hospital Organizations will provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility for Financial Assistance or for government assistance in CHI Hospital Facilities.

Other Medically Necessary Care - CHI Hospital Organizations are committed to providing Financial Assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for non-emergent Medically Necessary Care provided in CHI Hospital Facilities.

APPLICATION

This Policy applies to:

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[1] A Direct Affiliate is any corporation of which CHI is the sole corporate member or sole shareholder.

[2] A Subsidiary refers to *either* an organization, whether nonprofit or for-profit, in which a Direct Affiliate holds the power to appoint a majority of the voting members of the governing body of such organization *or* any organization in which a Subsidiary holds such power.

- All charges for EMCare provided in a Hospital Facility by a CHI Hospital Organization.
- All charges for EMCare provided by a physician or advanced practice clinician (APC) who is employed by a CHI Hospital Organization to the extent such care is provided within a Hospital Facility.
- All charges for EMCare provided by a physician or APC who is employed by a Substantially Related Entity that occurs within a Hospital Facility.
- Collection and recovery activities conducted by the Hospital Facility or a designated supplier of billing and collections services (Designated Supplier), or its third-party collection agents (whether debt is referred or sold) of a Hospital Organization to collect amounts owed for EMCare described above. All third-party agreements governing such collection and recovery activities must include a provision requiring compliance with this Policy and indemnification for failures as a result of its noncompliance. This includes, but is not limited to, agreements between third parties who subsequently sell or refer debt of the Hospital Facility.

Coordination with Other Laws

The provision of Financial Assistance may now or in the future be subject to additional regulation pursuant to federal, state or local laws. Such law governs to the extent it imposes more stringent requirements than this Policy. In the event that such law directly conflicts with this Policy, the CHI Hospital Organization shall, after consultation with its local CHI Legal Services Group representative, CHI Revenue Cycle leadership, and CHI Tax leadership, adopt a separate policy, with such minimal changes to this Policy as are as necessary to ensure compliance with Internal Revenue Code (IRC) Section 501(r) and other applicable laws.

PURPOSE

Pursuant to IRC Section 501(r), in order to remain tax-exempt, each CHI Hospital Organization is required to establish a written Financial Assistance Policy (FAP) and an Emergency Medical Care Policy which apply to all EMCare provided in a Hospital Facility. The purpose of this Policy is to describe the conditions under which a Hospital Facility provides Financial Assistance to its patients. In addition, this Policy describes the actions a Hospital Facility may take with respect to delinquent patient accounts.

DEFINITIONS

Amounts Generally Billed (AGB) means the amounts generally billed for EMCare to individuals who have insurance covering such care. The Hospital Facility determines AGB using the Prospective Medicare method. However, a patient eligible for Financial Assistance will only be extended free care under this Policy. Thus, no FAP eligible individual will be charged in excess of AGB for EMCare. Therefore, it is not considered necessary to take additional measures to determine if a patient is responsible for more than AGB for EMCare.

Application Period means the time provided to patients by the CHI Hospital Organization to complete the Financial Assistance application. It begins on the first day care is provided and ends on the 240th day after the Hospital Facility provides the individual with the first post-discharge billing statement for the care provided.

CHI Entity Service Area means, for purposes of this Policy, the community served by a Hospital Facility as described in its most recent Community Health Needs Assessment, as described in IRC Section 501(r)(3).

Community Health Needs Assessment (CHNA) is conducted by a Hospital Facility at least once every three (3) years pursuant to IRC Section 501(r)(1)(A); each CHI Hospital Organization then adopts strategies to meet the community health needs identified through the CHNA.

Eligibility Determination Period - For purposes of determining Financial Assistance eligibility, a Hospital Facility will review annual household income from the prior six-month period or the prior tax year as shown by recent pay stubs or income tax returns and other information. Proof of earnings may be determined by annualizing the year-to-date household income, taking into consideration the current earnings rate.

Eligibility Qualification Period - After submitting the Financial Assistance application and supporting documents, patients approved to be eligible shall be granted Financial Assistance prospectively, for a period of six months from the determination date. Financial Assistance will also be applied to all eligible accounts incurred for services received six months prior to determination date. If eligibility is approved based on Presumptive Eligibility criteria, Financial Assistance will be applied to all eligible accounts incurred for services received six months prior to the determination date.

Emergency Medical Care, EMTALA - Any patient seeking urgent or emergent care [within the meaning of Section 1867 of the Social Security Act (42 U.S.C. 1395dd)] at a Hospital Facility shall

be treated without discrimination and without regard to a patient's ability to pay for care. Furthermore, any action that discourages patients from seeking emergency medical care, including, but not limited to, demanding payment before treatment or permitting debt collection and recovery activities that interfere with the provision of emergency medical care, is prohibited. Hospital Facilities shall also operate in accordance with all federal and state requirements for the provision of urgent or emergent health care services, including screening, treatment and transfer requirements under the federal Emergency Medical Treatment and Labor Act (EMTALA) and in accordance with 42 CFR 482.55 (or any successor regulation). Hospital Facilities should consult and be guided by their emergency services policy, EMTALA regulations, and applicable Medicare/Medicaid Conditions of Participation in determining what constitutes an urgent or emergent condition and the processes to be followed with respect to each.

Extraordinary Collection Actions (ECAs) - The Hospital Facility will not engage in ECAs against an individual prior to making a reasonable effort to determine eligibility under this Policy. An ECA may include any of the following actions taken in an effort to obtain payment on a bill for care:

- Selling an individual's debt to another party except as expressly provided by federal tax law;
- Certain actions that require a legal or judicial process as specified by federal tax law; and
- Reporting adverse information about the individual to consumer credit bureaus.

ECAs do not include any lien that a Hospital Facility is entitled to assert under state law on the proceeds of a judgment, , or compromise owed to an individual (or his or her representative) as a result of personal injuries for which the Facility provided care.

Family means (using the Census Bureau definition) a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal Revenue Service rules, if the patient claims someone as a dependent on his or her income tax return, that person may be considered a dependent for purposes of the provision of Financial Assistance. If IRS tax documentation is not available, family size will be determined by the number of dependents documented on the Financial Assistance application and verified by the Hospital Facility.

Family Income is determined consistent with the Census Bureau definition, which uses the following when computing federal poverty guidelines:

- Includes earnings, unemployment compensation, Worker's Compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts,

educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources, on a before-tax basis;

- Excludes noncash benefits (such as food stamps and housing subsidies);
- Excludes capital gains or losses; and
- Includes the income of all family members, if a person lives with a family, but excludes non-relatives, such as housemates.

Federal Poverty Guidelines (FPG) are updated annually in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code. Current guidelines can be referenced at http://aspe.hhs.gov/poverty-guidelines.

Financial Assistance means assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for EMCare provided in a Hospital Facility and who meet the eligibility criteria for such assistance. Financial Assistance is offered to insured patients to the extent allowed under the patient's insurance carrier contract.

Guarantor means an individual other than the patient who is legally responsible for payment of the patient's bill.

Hospital Facility (or Facility) means a healthcare facility that is required by a state to be licensed, registered or similarly recognized as a hospital and that is operated by a CHI Hospital Organization.

Medically Necessary Care means any procedure reasonably determined to prevent, diagnose, correct, cure, alleviate, or avert the worsening of conditions that endanger life, cause suffering or pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, if there is no other equally effective, more conservative or less costly course of treatment available.

Operates a Hospital Facility - A Hospital Facility is considered to be operated either by use of its own employees or by contracting out the operation of the Facility to another organization. A Hospital Facility may also be operated by a CHI Hospital Organization if the CHI Hospital Organization has a capital or profits interest in an entity taxed as a partnership which directly operates a state licensed Hospital Facility or which indirectly operates a state licensed Hospital Facility through another entity taxed as a partnership.

Presumptive Financial Assistance means the determination of eligibility for Financial Assistance that may rely on information provided by third-party vendors and other publically available information. A determination that a patient is presumptively eligible for Financial Assistance will result in free EMCare for the period during which the individual is presumptively eligible.

Substantially-Related Entity means, with respect to a CHI Hospital Organization, an entity treated as a partnership for federal tax purposes in which the Hospital Organization owns a capital or profits interest, or a disregarded entity of which the Hospital Organization is the sole member or owner, that provides EMCare in a state licensed Hospital Facility, unless the provision of such care is an unrelated trade or business described in IRC Section 513 with respect to the Hospital Organization.

Uninsured means an individual having no third-party coverage by a commercial third-party insurer, an ERISA plan, a Federal Health Care Program (including without limitation Medicare, Medicaid, SCHIP and CHAMPUS), Worker's Compensation, or other third-party assistance to assist with meeting his or her payment obligations.

Underinsured means an individual with private or public insurance coverage, for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for EMCare covered by this Policy.

ELIGIBILITY FOR FINANCIAL ASSISTANCE

Financial Assistance Available for EMCare

Financial Assistance shall be provided to patients who meet the eligibility requirements as described herein and reside within the CHI Entity Service Area as defined by the most recent Hospital Facility CHNA. A patient who qualifies for Financial Assistance will receive free EMCare, and as such will never be responsible for more than AGB for EMCare.

Financial Assistance Not Available for Other Than EMCare

Financial Assistance is not available for care other than EMCare. In the case of other than EMCare, no patient will be responsible for more than the net charges for such care (gross charges for such care after all deductions and insurance reimbursements have been applied).

Eligibility for Financial Assistance will be considered for those individuals who are Uninsured, Underinsured, ineligible for any government health care benefit program, and who are unable to pay

for their care, based upon a determination of financial need in accordance with this Policy. The granting of Financial Assistance shall be based on an individualized determination of financial need, and shall not take into account any potential discriminatory factors such as age, ancestry, gender, gender identity, gender expression, race, color, national origin, sexual orientation, marital status, social or immigrant status, religious affiliation, or any other basis prohibited by federal, state, or local law.

Unless eligible for Presumptive Financial Assistance, the following eligibility criteria must be met in order for a patient to qualify for Financial Assistance:

- The patient must have a minimum account balance of thirty-five dollars ($35.00) with the CHI Hospital Organization. Multiple account balances may be combined to reach this amount. Patients/Guarantors with balances below thirty-five dollars ($35) may contact a financial counselor to make monthly installment payment arrangements.
- The patient's Family Income must be at or below 300% of the FPG.
- The patient must comply with Patient Cooperation Standards as described herein.
- The patient must submit a completed Financial Assistance application.

Patient Cooperation Standards

A patient must exhaust all other payment options, including private coverage, federal, state and local medical assistance programs, and other forms of assistance provided by third-parties prior to being approved. An applicant for Financial Assistance is responsible for applying to public programs for available coverage. He or she is also expected to pursue public or private health insurance payment options for care provided by a CHI Hospital Organization within a Hospital Facility. A patient's and, if applicable, any Guarantor's cooperation in applying for applicable programs and identifiable funding sources, including COBRA coverage (a federal law allowing for a time-limited extension of employee healthcare benefits), shall be required. If a Hospital Facility determines that COBRA coverage is potentially available, and that a patient is not a Medicare or Medicaid beneficiary, the patient or Guarantor shall provide the Hospital Facility with information necessary to determine the monthly COBRA premium for such patient, and shall cooperate with Hospital Facility staff to determine whether he or she qualifies for Hospital Facility COBRA premium assistance, which may be offered for a limited time to assist in securing insurance coverage. A Hospital Facility shall make affirmative efforts to help a patient or patient's Guarantor apply for public and private programs.

THE METHOD FOR APPLYING FOR FINANCIAL ASSISTANCE

All patients must complete the CHI Financial Assistance Application (FAA) to be considered for Financial Assistance, unless they are eligible for Presumptive Financial Assistance. The FAA is used by the Hospital Facility to make an individual assessment of financial need.

To qualify for assistance, at least one piece of supporting documentation that verifies household income is required to be submitted along with the FAA. Supporting documentation may include, but is not limited to:

- Copy of the individual's most recently filed federal income tax return;
- Current Form W-2;
- Current paystubs; or
- Signed letter of support.

The Hospital Facility may, at its discretion, rely on evidence of eligibility other than described in the FAA or herein. Other evidentiary sources may include:

- External publically available data sources that provide information on a patient/Guarantor's ability to pay;
- A review of patient's outstanding accounts for prior services rendered and the patient/Guarantor's payment history;
- Prior determinations of the patient's or Guarantor's eligibility for assistance under this Policy, if any; or
- Evidence obtained as a result of exploring appropriate alternative sources of payment and coverage from public and private payment programs.

In the event no income is evidenced on a completed FAA, a written document is required which describes why income information is not available and how the patient or Guarantor supports basic living expenses (such as housing, food, and utilities). Financial Assistance applicants who participate in the National Health Services Corps (NHSC) Loan Repayment Program are exempt from submitting expense information.

PRESUMPTIVE ELIGIBILITY

CHI Hospital Organizations recognize that not all patients and Guarantors are able to complete the FAA or provide requisite documentation. Financial counselors are available at each Hospital Facility location to assist any individual seeking application assistance. For patients and Guarantors who are unable to provide required documentation, a Hospital Facility may grant Presumptive Financial Assistance based on information obtained from other resources. In particular, presumptive eligibility may be determined on the basis of individual life circumstances that may include:

- Recipient of state-funded prescription programs;
- Homeless or one who received care from a homeless clinic;
- Participation in Women, Infants and Children programs (WIC);
- Food stamp eligibility;
- Subsidized school lunch program eligibility;
- Eligibility for other state or local assistance programs (e.g., Medicaid spend-down);
- Low income/subsidized housing is provided as a valid address; or
- Patient is deceased with no known estate.

This information will enable Hospital Facilities to make informed decisions on the financial needs of patients, utilizing the best estimates available in the absence of information provided directly by the patient. A patient determined eligible for Presumptive Financial Assistance will receive free EMCare for the period during which the individual is presumptively eligible.

If an individual is determined to be presumptively eligible, a patient will be granted Financial Assistance for a period of six months ending on the date of presumptive eligibility determination. As a result, Financial Assistance will be applied to all eligible accounts incurred for services received six months prior to the determination date. The presumptively eligible individual will not receive financial assistance for EMCare rendered after the date of determination without completion of a FAA or a new determination of presumptive eligibility.

For patients, or their Guarantors, who are non-responsive to a Hospital Facility's application process, other sources of information may be used to make an individual assessment of financial need. This information will enable the Hospital Facility to make an informed decision on the financial need of non-responsive patients, utilizing the best estimates available in the absence of information provided directly by the patient.

For the purpose of helping financially needy patients, a Hospital Facility may use a third party to review a patient's, or the patient's Guarantor's, information to assess financial need. This review utilizes a healthcare industry-recognized, predictive model that is based on public record databases. The model incorporates public record data to calculate a socio-economic and financial capability score. The model's rule set is designed to assess each patient based upon the same standards and is calibrated against historical Financial Assistance approvals by the Hospital Facility. This enables the Hospital Facility to assess whether a patient is characteristic of other patients who have historically qualified for Financial Assistance under the traditional application process.

When the model is utilized, it will be deployed prior to bad debt assignment after all other eligibility and payment sources have been exhausted. This allows a Hospital Facility to screen all patients for Financial Assistance prior to pursuing any ECAs. The data returned from this review will constitute adequate documentation of financial need under this Policy.

In the event a patient does not qualify for presumptive eligibility, the patient may still provide requisite information and be considered under the traditional FAA process.

Patient accounts granted presumptive eligibility status will be provided free care for eligible services for retrospective dates of service only. This decision will not constitute a state of free care as available through the traditional application process. These accounts will be treated as eligible for Financial Assistance under this Policy. They will not be sent to collection, will not be subject to further collection action, and will not be included in Hospital Facility bad debt expense. Patients will not be notified to inform them of this decision.

Presumptive screening provides a community benefit by enabling a CHI Hospital Organization to systematically identify financially needy patients, reduce administrative burdens, and provide Financial Assistance to patients and their Guarantors, some of whom may have not been responsive to the FAA process.

NOTIFICATION ABOUT FINANCIAL ASSISTANCE

Notification about the availability of Financial Assistance from CHI Hospital Organizations shall be disseminated by various means, which may include, but not be limited to:

- Conspicuous publication of notices in patient bills;

- Notices posted in emergency rooms, urgent care centers, admitting/registration departments, business offices, and at other public places as a Hospital Facility may elect; and
- Publication of a summary of this Policy on the Hospital Facility's website, www.catholichealth.net, and at other places within the communities served by the Hospital Facility as it may elect.

Such notices and summary information shall include a contact number and shall be provided in English, Spanish, and other primary languages spoken by the population served by an individual Hospital Facility, as applicable.

Referral of patients for Financial Assistance may be made by any member of the CHI Hospital Organization non-medical or medical staff, including physicians, nurses, financial counselors, social workers, case managers, chaplains, and religious sponsors. A request for assistance may be made by the patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws.

CHI Hospital Organizations will provide financial counseling to patients about their bills related to EMCare and will make the availability of such counseling known. It is the responsibility of the patient or the patient's Guarantor to schedule consultations regarding the availability of Financial Assistance with a financial counselor.

ACTIONS IN THE EVENT OF NON-PAYMENT

The actions a CHI Hospital Organization may take in the event of nonpayment with respect to each Hospital Facility are described in a separate policy, Stewardship Policy No. 16, *Billing and Collections*. Members of the public may obtain a free copy of this Policy by asking the Hospital Facility Patient Access/Admitting department or by contacting 1-800-514-4637.

APPLICATION OF PROCEDURES

Revenue cycle teams are responsible for the implementation of this Policy in accordance with the detailed procedures set forth in CHI Revenue Cycle Procedures, as amended.

POLICY APPROVAL

This Policy is subject to periodic review every three (3) years or earlier, as required by changes in applicable law. Any changes to the Policy must be approved by the CHI Board of Stewardship Trustees.

ATTACHMENTS

A Financial Assistance Application (FAA)
B Provider Listing - an appendix to this Policy that will initially be published by each CHI Hospital Facility on its website, on or before July 1, 2016, and will be updated by management periodically (but no less than quarterly) thereafter.

RELATED POLICIES

- Clinical Effectiveness Policy No. 6, *EMTALA*
- Stewardship Policy No. 16, *Billing and Collections*

APPROVED AND AMENDED BY THE BOARD

- 03/09/16 (to be effective 07/01/16)
- 12/07/16

A spirit of innovation, a legacy of care.

PURPOSE

This Addendum 1 modifies and supplements CHI Stewardship Policy 15 – *Financial Assistance* ("Policy 15") as necessary to comply with Washington statutes and regulations regarding provision of Hospital Charity Care, in accordance with the "Coordination with Other Laws" section of Policy 15. This Addendum 1 applies to all Catholic Health Initiatives Direct Affiliates and Tax-Exempt Subsidiaries in the state of Washington, as defined in Policy 15.

For ease of reference, section headings in this Addendum 1 correspond with the section headings of Policy 15. Facility revenue cycle teams along with Hospital Facility leadership are responsible for the implementation of this Addendum 1 and Policy 15.

POLICY

References in Policy 15 to Emergency and other Medically Necessary Care (EMCare) are to be interpreted consistently with the definitions of "Appropriate Hospital Facility-based medical services" and "Emergency care or emergency services" contained in WAC 246-453-010(7) and (11), respectively.

DEFINITIONS

"Family Income" means total cash receipts before taxes derived from wages and salaries, welfare payments, Social Security payments, strike benefits, unemployment or disability benefits, child support, alimony, and net earnings from business and investment activities paid to the individual, in accordance with WAC 246-453-020 (17).

ELIGIBILITY FOR FINANCIAL ASSISTANCE

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

2. "Patient Cooperation Standards," as defined in Policy 15, shall only apply to the extent they will:

    - allow the Hospital Facility to pursue reimbursement from any third-party coverage that may be identified to the Hospital Facility, in accordance with WAC 246-453-020(1);

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

THE METHOD FOR APPLYING FOR FINANCIAL ASSISTANCE

1. For the purposes of reaching an initial determination of sponsorship status, Hospital Facilities shall rely upon information provided orally by the responsible party. The Hospital Facility may require the responsible party to sign a statement attesting to the accuracy of the information provided to the Hospital Facility for purposes of the initial determination of sponsorship status, in accordance with WAC 246-453-030(1).

2. In accordance with WAC 246-453-030(2), in addition to the documents listed in Policy 15, any one of the following documents shall be considered sufficient evidence upon which to base the final determination of charity care sponsorship status, when the income information is annualized as may be appropriate:

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

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

4. Hospital Facilities shall make every reasonable effort to reach initial and final determinations of eligibility for financial assistance in a timely manner. Nevertheless, Hospital Facilities shall make those determinations at any time, even after the

Application Period, upon learning of facts or receiving the documentation described herein, indicating that the responsible party's income is equal to or below two hundred percent (200%) of the federal poverty guidelines as adjusted for family size. The timing of reaching a final determination of eligibility for financial assistance shall have no bearing on the Hospital Facility's identification of charity care deductions from revenue as distinct from bad debts. WAC 246-453-020(10).

5. Any responsible party who has been initially determined to meet the criteria for receiving financial assistance shall be provided with at least fourteen (14) calendar days or such time as the person's medical condition may require, or such time as may be reasonably necessary to secure and to present documentation described within WAC 246-453-020(3) prior to receiving a final determination of sponsorship status.

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

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

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

9. In the event that the Hospital Facility denies the responsible party's application for financial assistance, the Hospital Facility shall notify the responsible party of the denial and the basis for the denial.

10. In the event that a responsible party pays a portion or all of the charges related to appropriate EMCare, and is subsequently found to have met the financial assistance

criteria at the time that services were provided, any payments in excess of the amount determined to be appropriate shall be refunded to the patient within thirty (30) days of achieving the charity care designation. WAC 246-453-020(11).

PRESUMPTIVE ELIGIBILITY

1. In the event the responsible party's identification as an indigent person is obvious to Hospital Facility personnel, and the Hospital Facility personnel are able to establish the position of the income level within the broad criteria described in WAC 246-453-040, based on the individual life circumstances contained within Policy 15 or otherwise, the Hospital Facility is not obligated to establish the exact income level or to request documentation from the responsible party, unless the responsible party requests further review.

ADDITIONAL PROVISION – APPEALS

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

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

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

All Policies Site - CHI Franciscan Health System

Origination:	*03/2014*
Effective:	*06/2020*
Last Approved:	*06/2020*
Last Revised:	*06/2020*
Next Review:	*06/2023*
Owner:	*Rose Shandrow: Div Director Mission*
Policy Area:	*Corporate Ethics/Privacy*
References:	*Administrative*
Applicability:	*CHI Franciscan Systemwide*

End of Life, 044.00

PURPOSE

Provide guidance and support for our system policy on respect of life.

POLICY STATEMENTS

COPY

It is the policy of all CHI Franciscan Health System hospitals that all services rendered in our facilities shall be supportive of life. The hospital's goal is to help patients make informed decisions about end of life care without the hospital actively participating in the provisions associated with the Death with Dignity Act.
It is the policy of each hospital to provide tools and support to a patient and their family that improves their quality of life when facing the problems associated with life threatening illness.

At no time may direct actions to terminate life be performed or permitted within CHI Franciscan Health System hospitals and clinics.

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

PATIENT AND FAMILY SUPPORT

Access to Spiritual Care Services, Hospice Care and Palliative Medical Services are available within CHI Franciscan facilities to support the quality of end of life.
Upon request, the hospital will provide each adult patient with information about their rights under Washington (WA) state law to make decision concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives. The hospital policy of accepting the patient's or his/her surrogate decision-maker's decision concerning life-sustaining treatment **does not** include assisted suicide or euthanasia.
Initiating Ethics Committee Consults, may be requested to advise on policy statements and guidelines for decision-making where ethical considerations are involved. Medical Staff, staff and family/surrogate decision makers may request a consult.

REQUIRED REVIEW

Senior Vice President of Mission

End of Life, 044.00. Retrieved 06/17/2020. Official copy at http://chifranciscan-all.policystat.com/policy/8186343/. Copyright © 2020 All Policies Site - CHI Franciscan Health System

Attachments

No Attachments

Approval Signatures

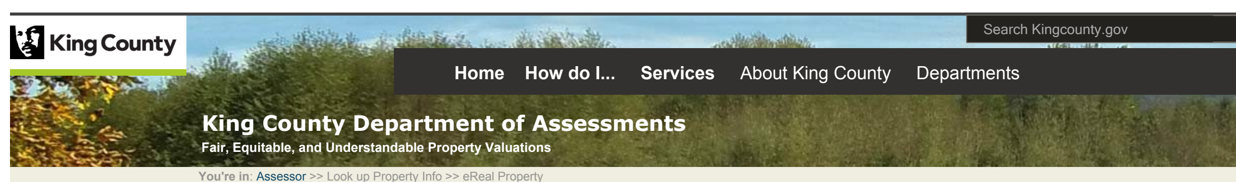
Approver	Date
Joan VanSickle: Document Control Coordinator	06/2020
Rose Shandrow: Div Director Mission	06/2020

Applicability

CHI Franciscan Health, Harrison Medical Center, Highline Medical Center, St. Anthony Hospital, St. Clare Hospital, St. Elizabeth Hospital, St. Francis Hospital, St. Joseph Medical Center

COPY

Exhibit 8
King County Assessor Information



Department of Assessments

500 Fourth Avenue, Suite ADM-AS-0708, Seattle, WA 98104

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

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

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

PARCEL

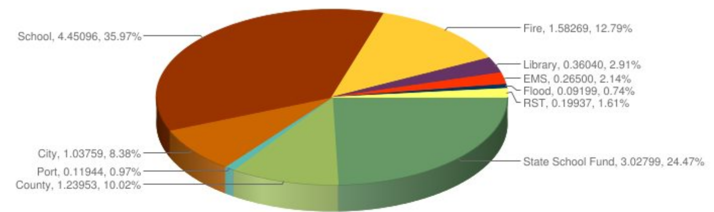
Parcel Number	302304-9027
Name	CHI FRANCISCAN
Site Address	16251 SYLVESTER RD SW 98166
Legal	BURIEN LLA (CONSOLIDATION) #LLA 08-1484 REC 20080805900003 SD LLA LOCATED IN W 1/2 OF NW 1/4 OF NE 1/4 OF 30-23-04

BUILDING 1

Year Built	1957
Building Net Square Footage	139868
Construction Class	WOOD FRAME
Building Quality	AVERAGE
Lot Size	289123
Present Use	Hospital
Views	No
Waterfront	

TOTAL LEVY RATE DISTRIBUTION

Tax Year: 2020 **Levy Code:** 0937 **Total Levy Rate:** $12.37496 **Total Senior Rate:** $6.29129



53.34% Voter Approved

Click here to see levy distribution comparison by year.

TAX ROLL HISTORY

Valued Year	Tax Year	Appraised Land Value ($)	Appraised Imps Value ($)	Appraised Total ($)	Appraised Imps Increase ($)	Taxable Land Value ($)	Taxable Imps Value ($)	Taxable Total ($)
2020	2021	4,409,100	71,296,700	75,705,800	0	0	0	0
2019	2020	4,336,800	71,290,800	75,627,600	0	0	0	0
2018	2019	4,047,700	69,647,900	73,695,600	0	0	0	0
2017	2018	4,047,700	67,252,800	71,300,500	0	0	0	0
2016	2017	4,047,700	64,047,900	68,095,600	1,000,000	0	0	0
2015	2016	4,047,700	40,415,600	44,463,300	289,200	0	0	0
2014	2015	4,047,700	40,878,800	44,926,500	1,801,200	0	0	0
2013	2014	4,047,700	39,077,600	43,125,300	0	0	0	0
2012	2013	4,047,700	39,171,300	43,219,000	0	0	0	0
2011	2012	4,047,700	39,600,800	43,648,500	0	0	0	0
2010	2011	4,915,000	37,722,400	42,637,400	0	0	0	0
2009	2010	4,915,000	38,625,300	43,540,300	0	0	0	0
2008	2009	4,915,000	35,875,600	40,790,600	0	0	0	0
2007	2008	4,919,000	34,898,700	39,817,700	0	0	0	0
2006	2007	3,663,100	32,030,500	35,693,600	0	0	0	0
2005	2006	1,958,900	31,439,000	33,397,900	0	0	0	0
2004	2005	1,958,900	28,727,800	30,686,700	0	0	0	0
2003	2004	1,958,900	28,537,500	30,496,400	300,000	0	0	0

Reference Links:

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

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Notice mailing date: 07/23/2020

2002	2003	1,469,100	23,769,000	25,238,100	1,000,000	0	0	0
2001	2002	1,469,200	22,184,700	23,653,900	0	0	0	0
2000	2001	1,469,200	21,556,900	23,026,100	0	0	0	0
1999	2000	1,469,200	20,605,800	22,075,000	6,191,000	0	0	0
1997	1998	0	0	0	0	1,469,200	12,492,800	13,962,000
1996	1997	0	0	0	0	1,220,300	12,492,800	13,713,100
1994	1995	0	0	0	0	1,125,300	12,492,800	13,618,100
1992	1993	0	0	0	0	1,125,300	12,492,800	13,618,100
1990	1991	0	0	0	0	900,200	15,241,900	16,142,100
1989	1990	0	0	0	0	618,900	15,523,200	16,142,100
1988	1989	0	0	0	0	618,900	12,492,800	13,111,700
1987	1988	0	0	0	0	470,400	12,492,800	12,963,200
1986	1987	0	0	0	0	473,600	12,492,800	12,966,400
1985	1986	0	0	0	0	473,600	12,492,800	12,966,400
1984	1985	0	0	0	0	473,600	5,905,500	6,379,100
1983	1984	0	0	0	0	227,100	2,598,000	2,825,100
1982	1983	0	0	0	0	227,100	2,123,500	2,350,600

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Updated: Jan. 29, 2019

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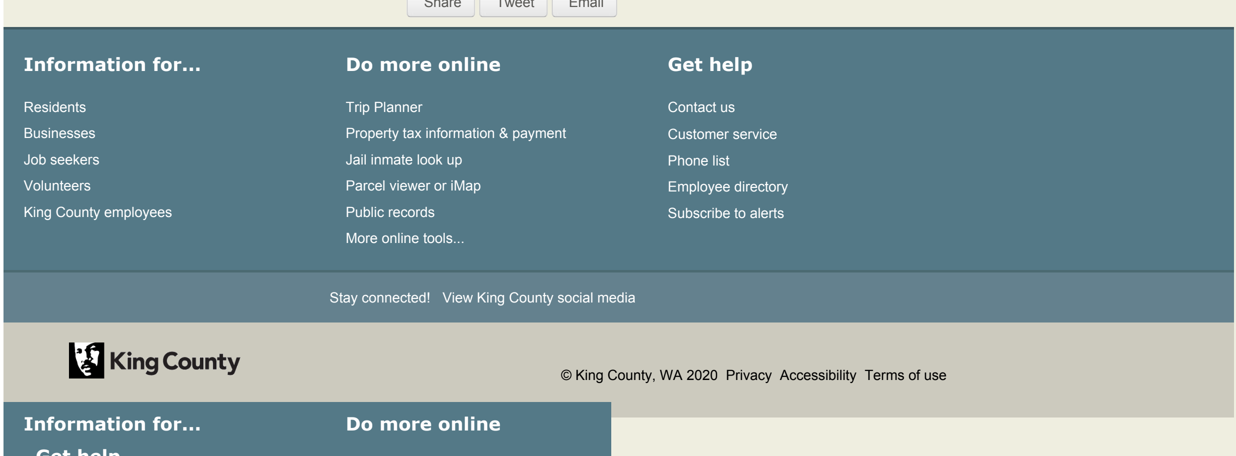

Exhibit 9
CHI Franciscan Facility Listing

Facility Listing

Facility/Agency	Address	Medicare Provider No.	Medicaid Provider No.	Owned/ Managed
St. Joseph Medical Center	1717 S. "J" Street Tacoma, WA 98405	50-0108	3309309	Owned
St. Clare Hospital	11315 Bridgeport Way SW Lakewood, WA 98499	50-0021	3300258	Owned
St. Francis Hospital	34515 9th Avenue S. Federal Way, WA 98003	50-0141	3300118	Owned
Enumclaw Regional Hospital Association dba St. Elizabeth Hospital	1450 Battersby Avenue Enumclaw, WA 98022	50-1335	3310406	Owned
St. Anthony Hospital	11567 Canterwood Blvd NW Gig Harbor, WA 98332	50-0151	3300597	Owned
Franciscan Hospice Care Center	2901 Bridgeport Way University Place, WA 98467	50-0108	3309309	Owned
Gig Harbor Same Day Surgery	6401 Kimball Drive Gig Harbor, WA 98335	50-0108	3309309	Owned
Franciscan Hospice	2901 Bridgeport Way University Place, WA 98467	50-1526	3990264	Owned
Highline Medical Center, a non profit corporation	16251 Sylvester Road SW Burien, WA 98166	50-0011 (hospital) 50-7094 (home health) 50-1527 (hospice)	1013171 (hospital) 1015012 (home health) 1006162 (hospice)	Owned
Harrison Medical Center, a non profit corporation	2520 Cherry Avenue Bremerton, WA 98310 1800 NW Myhre Road Silverdale, WA, 98383	50-0039 (hospital) 50-7076 (home health agency)	3303500 (hospital) 9008533 (home health agency)	Affiliated

Appendix 1
Audited Financials

COMMONSPIRIT HEALTH

Consolidated Financial Statements as of and for the Years Ended June 30, 2019 and 2018 With Report of Independent Auditors

COMMONSPIRIT HEALTH

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REPORT OF INDEPENDENT AUDITORS 1

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Consolidated Statements of Cash Flows 6-7

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Suite 1700
18101 Von Karman Avenue
Irvine, CA 92612

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Fax: +1 949 437 0590
ey.com

Report of Independent Auditors

The Board of Stewardship Trustees
CommonSpirit Health

We have audited the accompanying consolidated financial statements of CommonSpirit Health, which comprise the consolidated balance sheets as of June 30, 2019 and 2018, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity 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 financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the 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 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 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 financial statements referred to above present fairly, in all material respects, the consolidated financial position of CommonSpirit Health as of June 30, 2019 and 2018, and the consolidated results of its operations and its cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Ernst & Young LLP

October 4, 2019

A member firm of Ernst & Young Global Limited

COMMONSPIRIT HEALTH

CONSOLIDATED BALANCE SHEETS
JUNE 30, 2019 AND 2018 (in millions)

Assets	2019	2018
Current assets:		
Cash and cash equivalents	$ 1,569	$ 510
Short-term investments	2,511	-
Assets limited as to use	2,315	218
Patient accounts receivable, net of allowance for doubtful accounts of $827 in 2018	3,726	2,122
Broker receivables for unsettled investment trades	291	-
Provider fee receivable	964	43
Assets held for sale	223	196
Other current assets	1,403	642
Total current assets	13,002	3,731
Assets limited as to use:		
Designated assets for:		
Capital projects and other	7,519	5,309
Held for self-insured claims	1,551	869
Under bond indenture agreements for debt service	31	-
Donor-restricted	879	309
Other	397	197
Less amount required to meet current obligations	(2,315)	(218)
Assets limited as to use, net	8,062	6,466
Property and equipment, net	15,266	8,111
Ownership interests in health-related activities	3,145	1,733
Goodwill	242	239
Intangible assets, net	714	182
Other long-term assets, net	194	133
Total assets	$ 40,625	$ 20,595

(Continued)

CONSOLIDATED BALANCE SHEETS
JUNE 30, 2019 AND 2018 (in millions)

Liabilities and Net Assets	**2019**	**2018**
Current liabilities:		
Current portion of long-term debt	$ 3,475	$ 2,087
Demand bonds subject to short-term liquidity arrangements	820	97
Accounts payable	1,362	743
Accrued salaries and benefits	1,348	566
Self-insured reserves and claims	423	197
Broker payables for unsettled investment trades	403	-
Liabilities held for sale	162	252
Provider fee payables	335	13
Other accrued liabilities	1,190	801
Total current liabilities	9,518	4,756
Other liabilities - long-term:		
Self-insured reserves and claims	1,104	483
Pension and other postretirement benefit liabilities	3,692	865
Derivative instruments	214	33
Other	1,094	984
Total other liabilities - long-term	6,104	2,365
Long-term debt, net of current portion	9,212	6,342
Total liabilities	24,834	13,463
Net assets:		
Without donor restrictions - attributable to CommonSpirit Health	14,428	6,529
Without donor restrictions - noncontrolling interests	486	300
With donor restrictions	877	303
Total net assets	15,791	7,132
Total liabilities and net assets	$ 40,625	$ 20,595

See notes to consolidated financial statements.

COMMONSPIRIT HEALTH

CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS
YEARS ENDED JUNE 30, 2019 AND 2018 (in millions)

	2019	2018
Operating revenues:		
Patient revenue, net of contractual discounts and adjustments		$ 14,903
Provision for bad debts		(767)
Net patient revenue	$ 19,476	14,136
Premium revenue	476	53
Revenue from health-related activities, net	70	18
Other operating revenue	897	733
Contributions	47	42
Total operating revenues	20,966	14,982
Operating expenses:		
Salaries and benefits	10,161	7,111
Supplies	3,337	2,449
Purchased services and other	6,273	4,379
Depreciation and amortization	1,087	856
Interest expense, net	391	313
Total operating expenses	21,249	15,108
Operating loss before special charges and other costs	(283)	(126)
Special charges and other costs	(319)	(141)
Operating loss	(602)	(267)
Nonoperating income (loss):		
Investment income, net	612	443
Income tax expense	(14)	(10)
Change in fair value and cash payments of interest rate swaps	(131)	52
Contribution from business combination	9,155	-
Other	(6)	4
Total nonoperating income, net	9,616	489
Excess of revenues over expenses	$ 9,014	$ 222
Less excess of revenues over expenses attributable to noncontrolling interests	6	28
Excess of revenues over expenses attributable to CommonSpirit Health	$ 9,008	$ 194

(Continued)

COMMONSPIRIT HEALTH

CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS
YEARS ENDED JUNE 30, 2019 AND 2018 (in millions)

	Without Donor Restrictions			
	Attributable to CommonSpirit Health	Noncontrolling Interest	With Donor Restrictions	Total Net Assets
Balance, June 30, 2017	$ 7,048	$ 368	$ 311	$ 7,727
Excess of revenues over expenses	194	28	-	222
Contributions	-	-	42	42
Net assets released from restrictions for capital	21	-	(21)	-
Net assets released from restrictions for operations and other	-	-	(26)	(26)
Change in funded status of pension and other postretirement benefit plans	139	4	-	143
Loss from discontinued operations, net	(790)	(3)	-	(793)
Other	(83)	(97)	(3)	(183)
Decrease in net assets	(519)	(68)	(8)	(595)
Balance, June 30, 2018	6,529	300	303	7,132
Excess of revenues over expenses	9,008	6	-	9,014
Contribution from business combination	-	235	559	794
Contributions	-	-	69	69
Net assets released from restrictions for capital	28	-	(28)	-
Net assets released from restrictions for operations and other	-	-	(35)	(35)
Change in funded status of pension and other postretirement benefit plans	(1,026)	-	-	(1,026)
Loss from discontinued operations, net	(79)	-	-	(79)
Other	(32)	(55)	9	(78)
Increase in net assets	7,899	186	574	8,659
Balance, June 30, 2019	$ 14,428	$ 486	$ 877	$ 15,791

See notes to consolidated financial statements.

COMMONSPIRIT HEALTH

CONSOLIDATED STATEMENTS OF CASH FLOWS
YEARS ENDED JUNE 30, 2019 AND 2018 (in millions)

	2019	2018
Cash flows from operating activities:		
Change in net assets	$ 8,659	$ (595)
Adjustments to reconcile change in net assets to cash provided by operating activities:		
Net loss on deconsolidation of subsidiary	-	319
Depreciation and amortization	1,087	856
Provision for doubtful accounts	-	767
Health-related activities:		
Changes in equity of unconsolidated entities	(78)	(18)
Purchase of noncontrolling interest	12	155
Contribution from business combination	(9,949)	-
Net gain on disposal of assets	(24)	(46)
Asset impairment of discontinued operations	-	378
Noncash special charges and other	124	14
Change in fair value of swaps	104	(80)
Change in funded status of pension and other postretirement benefit plans	1,026	(139)
Pension cash contributions	(19)	(117)
Changes in certain assets and liabilities:		
Accounts receivable, net	(110)	(917)
Accounts payable	76	(83)
Self-insured reserves and claims	20	8
Accrued salaries and benefits	117	(64)
Changes in broker receivables/payables for unsettled investment trades	142	-
Provider fee assets and liabilities	152	14
Other accrued liabilities	130	20
Prepaid and other current assets	(30)	(4)
Other, net	49	68
Cash provided by operating activities before net change in investments and assets limited as to use	1,488	536
Net decrease in investments and assets limited as to use	409	198
Cash provided by operating activities	1,897	734

(Continued)

COMMONSPIRIT HEALTH

CONSOLIDATED STATEMENTS OF CASH FLOWS
YEARS ENDED JUNE 30, 2019 AND 2018 (in millions)

	2019	2018
Cash flows from investing activities:		
Purchases of property and equipment	(1,148)	(759)
Investments in health-related activities	(121)	(110)
Business acquisitions, net of cash acquired	665	(21)
Proceeds from asset sales	72	61
Cash distributions from health-related activities	109	50
Other, net	6	(17)
Cash used in investing activities	(417)	(796)
Cash flows from financing activities:		
Borrowings	580	910
Repayments	(869)	(1,044)
Swaps cash collateral (posted) received	(65)	84
Distributions to noncontrolling interests	(49)	(33)
Purchase of noncontrolling interests	(12)	(155)
Other	(6)	-
Cash used in financing activities	(421)	(238)
Net increase (decrease) in cash and cash equivalents	1,059	(300)
Cash and cash equivalents at beginning of the year	510	810
Cash and cash equivalents at end of the year	$ 1,569	$ 510
Components of cash and cash equivalents and investments at end of year:		
Cash and cash equivalents	$ 1,569	$ 510
Short-term investments	2,511	-
Designated assets for capital projects and other	7,519	5,309
Total	$ 11,599	$ 5,819
Supplemental disclosures of cash flow information:		
Cash paid for interest, net of capitalized interest	$ 430	$ 338
Supplemental schedule of noncash investing and financing activities:		
Property and equipment acquired through capital lease or note payable	$ 15	$ 19
Investments in health-related activities	$ 17	$ 11
Accrued purchases of property and equipment	$ 113	$ 44

See notes to consolidated financial statements.

1. ORGANIZATION

CommonSpirit Health (the "Corporation") is a Colorado nonprofit public benefit corporation exempt from federal and state income taxes. Effective February 1, 2019, Catholic Health Initiatives (dba "CHI") changed its name to CommonSpirit Health and became the sole corporate member of Dignity Health, a California nonprofit public benefit corporation also exempt from federal and state income taxes. CommonSpirit Health is a Catholic healthcare system sponsored by the public juridic person, Catholic Health Care Federation ("CHCF"). Due to the circumstances of the business combination between CHI and Dignity Health, through the alignment under CHCF, the transaction qualified for acquisition accounting with CommonSpirit Health as the accounting acquirer of Dignity Health.

CommonSpirit Health owns and operates health care facilities in 21 states and is the sole corporate member (parent corporation) of other primarily nonprofit corporations that are exempt from federal and state income taxes. CommonSpirit Health is comprised of 142 hospitals, including three academic health centers, major teaching hospitals, and 31 critical access facilities; community health services organizations; accredited nursing colleges; home health agencies; living communities; a medical foundation and other affiliated medical groups; and other facilities and services that span the inpatient and outpatient continuum of care. CommonSpirit Health also has two offshore and one onshore captive insurance companies. The accompanying consolidated financial statements include CommonSpirit Health and its direct affiliates and subsidiaries (together, "CommonSpirit").

CommonSpirit Health and substantially all of its direct affiliates and subsidiaries have been granted exemptions from federal income tax as charitable organizations under Section 501(c)(3) of the Internal Revenue Code.

The accompanying consolidated balance sheets and related consolidated statements of operations and changes in net assets and statements of cash flows reflect the financial position and results of operations of CHI as of and for the year ended June 30, 2018, and of CommonSpirit as of and for the year ended June 30, 2019. CommonSpirit's results of operations for the year ended June 30, 2019, include 12 months of results of operations and cash flows for CHI, and five months of results of operations and cash flows for Dignity Health from February 1, 2019 to June 30, 2019.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis for Presentation – The accompanying consolidated financial statements of CommonSpirit were prepared in accordance with accounting principles generally accepted in the United States of America ("GAAP") and include the accounts of CommonSpirit after elimination of intercompany transactions and balances.

Reclassifications – Certain reclassifications and changes in presentation were made in the 2018 consolidated financial statements to conform to the 2019 presentation. As previously presented, CommonSpirit classified net assets with no donor-imposed restriction as unrestricted. Such net assets are reported herein as net assets without donor restrictions. Also, as previously presented, CommonSpirit classified net assets with donor-imposed restrictions as either temporarily restricted or permanently restricted. Such net assets are reported herein as net assets with donor restrictions.

A crosswalk of the 2018 consolidated financial statement presentation to the 2019 presentation is provided below. The changes in presentation were made in part to separately present balances that became material to CommonSpirit in 2019, as a result of the affiliation with Dignity Health during the fiscal year. Other accounts were combined as they were no longer material to the CommonSpirit 2019 results.

(in millions)	As Originally Presented	Reclassifications	As Adjusted
Cash and equivalents	$ 510	$ -	$ 510
Current portion of investments and assets limited as to use	64	154	218
Patient accounts receivable, net	2,122	-	2,122
Other accounts receivable	257	(257)	-
Provider fee receivable	-	43	43
Inventories	299	(299)	-
Assets of discontinued operations and held for sale	196	-	196
Prepaid and other	144	(144)	-
Other current assets	-	642	642
Total investments and assets limited as to use, net of current portion	6,473	(7)	6,466
Property and equipment, net	8,111	-	8,111
Investments in unconsolidated organizations	1,733	-	1,733
Intangible assets and goodwill, net	421	(421)	-
Goodwill	-	239	239
Intangible assets, net	-	182	182
Notes receivable and other	265	(265)	-
Other long-term assets, net	-	133	133
Total assets	$ 20,595	$ -	$ 20,595
Commercial paper and current portion of debt	$ 2,087	$ -	$ 2,087
Variable-rate debt with self-liquidity	97	-	97
Compensation and benefits	569	(3)	566
Accounts payable	-	743	743
Third-party liabilities, net	132	(132)	-
Accounts payable and accrued expenses	1,480	(1,480)	-
Self-insured reserves and claims, current	-	197	197
Liabilities of discontinued operations and held for sale	252	-	252
Provider fee payables	-	13	13
Other accrued liabilities	-	801	801
Self-insured reserves and claims, long-term	623	(140)	483
Pension liability	854	(854)	-
Pension and other postretirement benefit liabilities	-	865	865
Derivative instruments	-	33	33
Other liabilities	1,027	(43)	984
Long-term debt	6,342	-	6,342
Total liabilities	$ 13,463	$ -	$ 13,463

The notable changes in presentation for the 2018 consolidated statement of operations include reclassifying $53 million of premium revenue out of other operating revenue, and $10 million of income tax expense out of other operating expenses into a separate line within nonoperating income (loss). Special charges and other costs represent 2018 restructuring, impairment and other losses as previously presented.

Use of Estimates – The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. CommonSpirit considers critical accounting policies to be those that require more significant judgments and estimates in the preparation of its consolidated financial statements, including the following: recognition of net patient revenue, which includes contractual discounts and adjustments; price concessions and charity care; fair value of acquired assets and assumed liabilities in business combinations; recorded values of depreciable and amortizable assets, investments and goodwill; reserves for self-insured workers' compensation and professional and general liabilities; contingent liabilities; and assumptions for measurement of pension and other postretirement benefit liabilities. Management bases its estimates on historical experience and various other assumptions that it believes are reasonable under the particular circumstances. Actual results could differ from those estimates.

Cash and Cash Equivalents – Cash and cash equivalents consist primarily of cash and liquid marketable securities with an original maturity of three months or less.

Inventories – Inventories, primarily consisting of pharmacy drugs and medical and surgical supplies, are stated at the lower of cost or net realizable value, determined using the first-in, first-out method.

Broker Receivables and Payables for Unsettled Investment Trades **–** CommonSpirit accounts for its investments on a trade date basis. Amounts due to/from brokers for investment activity represent transactions that have been initiated prior to the consolidated balance sheet date, but are formally settled subsequent to the consolidated balance sheet date.

Assets and Liabilities Held for Sale **–** Assets and liabilities held for sale represent assets and liabilities that are expected to be sold within one year. A group of assets and liabilities expected to be sold within one year is classified as held for sale if it meets certain criteria. The assets and liabilities held for sale are measured at the lower of carrying value or fair value less cost to sell. Such valuations include estimates of fair values generally based upon firm offers, discounted cash flows and incremental direct costs to transact a sale (Level 2 and Level 3 inputs).

Investments and Investment Income – The CommonSpirit Board of Stewardship Trustees Investment Committee establishes guidelines for investment decisions. Within those guidelines, CommonSpirit invests in equity and debt securities which are measured at fair value and are classified as trading securities. Accordingly, unrealized gains and losses on marketable securities are recorded within excess of revenues over expenses in the accompanying consolidated statements of operations and changes in net assets, and cash flows from the purchases and sales of marketable securities are reported as a component of operating activities in the accompanying consolidated statements of cash flows.

CommonSpirit also invests in alternative investments through limited partnerships. Alternative investments are comprised of private equity, real estate, hedge fund and other investment vehicles. CommonSpirit receives a proportionate share of the investment gains and losses of the partnerships. The limited partnerships generally contract with managers who have full discretionary authority over the investment decisions, within CommonSpirit's guidelines. These alternative investment vehicles invest in equity securities, fixed income securities, currencies, real estate, commodities, and derivatives.

CommonSpirit accounts for its ownership interests in these alternative investments under the equity method, the value of which is based on the net asset value ("NAV") practical expedient and is determined using investment valuations provided by the external investment managers, fund managers or general partners.

Alternative investments generally are not marketable and many alternative investments have underlying investments that may not have quoted market values. The estimated value of such investments is subject to uncertainty and could differ had a ready market existed. Such differences could be material. CommonSpirit's risk is limited to its capital investment in each investment and capital call commitments as discussed in Note 8.

Investment income or loss is included in excess of revenues over expenses unless the income or loss is restricted by donor or law. Income earned on tax-exempt borrowings for specific construction projects is offset against interest expense capitalized for such projects during construction.

Assets Limited as to Use – Assets limited as to use include assets set aside by CommonSpirit for future long-term purposes, including funding depreciation, to the extent that funds are available, to be used for replacement,

expansion and improvement of operating property and equipment. Assets limited as to use also include amounts held by trustees under bond indenture agreements, funds set aside for self-insurance programs, amounts contributed by donors with stipulated restrictions, and amounts held for mission and ministry purposes.

Liquidity – Cash and cash equivalents, short-term investments, patient and other accounts receivable, broker receivables, and provider fee receivables are the financial assets available to meet expected expenditure needs within the next year. Additionally, although intended to satisfy long-term obligations, management estimates that approximately 87% of designated assets for capital projects and other in assets limited as to use, as stated at June 30, 2019, could be utilized within the next year, if needed. CommonSpirit also has credit facility programs, as described in Note 15, available to meet unanticipated liquidity needs.

Deferred Financing Costs and Original Issue Discounts/Premiums on Bond Indebtedness – CommonSpirit amortizes deferred financing costs and original issue discounts/premiums on bond indebtedness over the estimated average period the related bonds will be outstanding, which approximates the effective interest method. Both deferred financing costs and original issue discounts/premiums are recorded with the related debt.

Property and Equipment – Property and equipment are stated at cost if purchased and at fair market value upon receipt if donated or upon the date of impairment if impaired. Depreciation of property and equipment is recorded using the straight-line method. Amortization of capital lease assets is included in depreciation expense. Estimated useful lives by major classification are as follows:

Land improvements	2 to 40 years
Buildings and improvements	5 to 40 years
Equipment	3 to 20 years
Software	3 to 10 years

Asset Impairment – CommonSpirit routinely evaluates the carrying value of its long-lived assets for impairment whenever events or changes in circumstances indicate that the carrying amount of the asset, or related group of assets, may not be recoverable from estimated future undiscounted cash flows generated by the underlying tangible assets. When the carrying value of an asset exceeds the estimated recoverability, an asset impairment charge is recognized. The impairment tests are based on financial projections prepared by management that incorporate anticipated results from programs and initiatives being implemented and market value assessments of the assets. If these projections are not met, or if negative trends occur that impact the future outlook, the value of the long-lived assets may be impaired.

Goodwill and indefinite-lived intangible assets are tested for impairment annually on various dates and when an event or circumstance indicates the value of the reporting unit or intangible asset may be impaired. CommonSpirit uses the income and market approaches to estimate the fair value of its reporting units and uses the income approach to estimate the fair value of its indefinite-lived intangible assets. If the carrying value exceeds the fair value, an impairment charge is recognized. See Notes 11 and 12.

Fair Value of Financial Instruments – The carrying amounts reported in the accompanying consolidated balance sheets for assets and liabilities, such as cash and cash equivalents, patient accounts receivable, interests in unconsolidated foundations, excess insurance receivables, community investment loans, broker receivables and payables on unsettled investment trades, accounts payable, and accrued expenses approximate fair value due to the nature of these items. The fair value of investments is disclosed in Note 8.

Derivative Instruments – CommonSpirit utilizes derivative arrangements to manage interest costs and the risk associated with changing interest rates. CommonSpirit records derivative instruments on the accompanying consolidated balance sheets as either an asset or liability measured at its fair value. See Notes 8 and 16.

CommonSpirit does not have derivative instruments that are designated as hedges. Interest cost and changes in fair value of derivative instruments are included in change in fair value and cash payments of interest rate swaps in nonoperating income, net, in the accompanying consolidated statements of operations and changes in net assets.

Ownership Interests in Health-Related Activities – Generally, when the ownership interest in health-related activities is more than 50% and CommonSpirit has a controlling interest, the ownership interest is consolidated, and a noncontrolling interest is recorded in net assets without donor restrictions. When the ownership interest is

at least 20%, but not more than 50%, or CommonSpirit has the ability to exercise significant influence over operating and financial policies of the investee, it is accounted for under the equity method, and the income or loss is reflected in revenue from health-related activities, net. Ownership interests for which CommonSpirit's ownership is less than 20% or for which CommonSpirit does not have the ability to exercise significant influence are carried at the lower of cost or estimated fair value. See Note 10.

Self-Insurance Plans – CommonSpirit maintains self-insurance programs for workers' compensation benefits for employees and for professional and general liability risks. Annual self-insurance expense under these programs is based on past claims experience and projected losses. Actuarial estimates of uninsured losses for each program at June 30, 2019 and 2018, have been accrued as liabilities and include an actuarial estimate for claims incurred but not reported ("IBNR"). CommonSpirit has insurance coverage in place for amounts in excess of the self-insured retention for workers' compensation and professional and general liabilities. The current and long-term portions of these liabilities are reflected accordingly in self-insured reserves and claims in the accompanying consolidated balance sheets.

CommonSpirit maintains separate trusts for these programs from which claims and related expenses and costs of administering the plans are paid. CommonSpirit's policy is to fund the trusts such that, over time, assets held equal liabilities for claims incurred for workers' compensation and claims made for professional liability risks.

CommonSpirit is also self-insured for certain employee medical benefits. The liability for IBNR claims for these benefits is included in self-insured reserves and claims within current liabilities in the accompanying consolidated balance sheets.

Patient Accounts Receivable, Allowance for Doubtful Accounts and Net Patient Revenue – Patient service revenue is reported at the amounts that reflect the consideration CommonSpirit expects to be paid in exchange for providing patient care. These amounts are due from patients, third-party payors (including health insurers and government programs), and others, and include consideration for retroactive revenue adjustments due to settlement of audits and reviews. Generally, performance obligations for patients receiving inpatient acute care services and outpatient services are recognized over time as services are provided. Net patient revenue is primarily comprised of hospital and physician services.

Performance obligations are generally satisfied over a period less than one year. As such, CommonSpirit has elected to apply the optional exemption provided in Financial Accounting Standards Board ("FASB") Accounting Standards Update ("ASU") No. 2015-14, *Revenue From Contracts with Customers (Topic 606),* and is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period.

CommonSpirit determines the transaction price based on standard charges for services provided, reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured and underinsured patients in accordance with CommonSpirit's financial assistance policy, and implicit price concessions provided to uninsured and underinsured patients. CommonSpirit determines its estimates of contractual adjustments and discounts based on contractual agreements, its discount policy, and historical experience. CommonSpirit determines its estimate of implicit price concessions based on its historical collection experience with these classes of patients using a portfolio approach as a practical expedient to account for patient contracts as collective groups rather than individually. CommonSpirit relies on the results of detailed reviews of historical write-offs and collections in estimating the collectability of accounts receivable. Updates to the hindsight analysis is performed at least quarterly using primarily a rolling eighteen-month collection history and write-off data. Subsequent changes to estimates of the transaction price are generally recorded as adjustments to net patient revenue in the period of the change.

Subsequent changes that are determined to be the result of an adverse change in a third-party payor's ability to pay are recorded as bad debt expense in purchased services and other in the accompanying consolidated statements of operations and changes in net assets. Bad debt expense for 2019 was not significant.

Agreements with third-party payors typically provide for payments at amounts less than established charges. A summary of the payment arrangements included in net patient revenue follows:

Medicare: Payments for inpatient services are generally made on a prospectively determined rate based on clinical diagnosis. Certain facilities receive cost-based reimbursement. Hospital outpatient services are

generally paid based on prospectively determined rates. Physician services are paid based upon established fee schedules.

Medicaid: Payments for inpatient services are generally made on a prospectively determined rate based on clinical diagnosis or on a per case or per diem basis. Hospital outpatient services and physician services are paid based upon established fee schedules, a cost basis reimbursement methodology, or discounts from established charges.

Commercial: Payments for inpatient and outpatient services provided to patients covered under commercial insurance policies are paid using a variety of payment methodologies, including per diem and case rates.

Self-Pay and Other: Payment agreements with uninsured or underinsured patients, along with other responsible entities, including institutions, other hospitals and other government payors, are based on a variety of payment methodologies.

Net patient revenue includes estimated settlements under payment agreements with third party payors. Settlements with third-party payors are accrued on an estimated basis in the period in which the related services are rendered and adjusted in future periods as final settlements are determined. These settlements are estimated and evaluated based on the terms of the payment agreement with the payor, correspondence from the payor, and historical settlement activity.

Premium Revenue – CommonSpirit has at-risk agreements with various payors to provide medical services to enrollees. Under these agreements, CommonSpirit receives monthly payments based on the number of enrollees, regardless of services actually performed by CommonSpirit. CommonSpirit accrues costs when services are rendered under these contracts, including estimates of IBNR claims and amounts receivable/payable under risk-sharing arrangements. The IBNR accrual includes an estimate of the costs of services for which CommonSpirit is responsible, including out-of-network services, and is recorded in other accrued liabilities.

Traditional Charity Care – Charity care is free or discounted health services provided to persons who cannot afford to pay and who meet CommonSpirit's criteria for financial assistance. The amount of services written off as charity quantified at customary charges was $1.2 billion and $934 million for 2019 and 2018, respectively. CommonSpirit estimates the cost of charity care by calculating a ratio of cost to usual and customary charges and applying that ratio to the usual and customary uncompensated charges associated with providing care to patients who qualify for charity care. This amount is not included in net patient revenue in the accompanying consolidated statements of operations and changes in net assets. The estimated cost of charity care associated with write-offs in 2019 and 2018 was $317 million and $226 million, respectively, for continuing operations, and $5 million and $18 million in 2019 and 2018, respectively, for discontinued operations. See Note 23.

Other Operating Revenue – Other operating revenue includes grant revenues, retail pharmacy revenues, management services revenues, rental revenues, cafeteria revenues, certain contributions released from restrictions, gains on sales of assets, and other nonpatient care revenues.

Contributions and Net Assets With Donor Restrictions – Gifts are reported as net assets with donor restrictions if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is met, net assets with donor restrictions related to capital purchases are reclassified as net assets without donor restrictions and reflected as net assets released from restrictions used for the purchase of property and equipment in the accompanying statements of operations and changes in net assets, whereas net assets with donor restrictions related to other gifts are reclassified as net assets without restrictions and recorded as other operating revenue. Gifts received with no restrictions are recorded as contributions in operating revenues. Gifts of long-lived operating assets, such as property and equipment, are reported as additions to net assets without donor restrictions, unless otherwise specified by the donor.

Unconditional promises to give cash and other assets to CommonSpirit are recorded at fair value at the date the promise is received using a discount rate of 2.0% to 5.5% and are generally due within five years. Conditional promises to give are recorded when the conditions have been substantially met. Donor indications of intentions to give are not recorded; such gifts are recorded at fair value only upon actual receipt of the gift. Investment income on net assets with donor restrictions is classified pursuant to the intent or requirement of the donor.

Endowment assets, which are primarily to be used for equipment and expansion, research and education, or charity purposes, include donor-restricted funds that the organization must hold in perpetuity or for a donor-specified period. Donor-restricted endowment net assets totaled $877 million and $303 million in 2019 and 2018, respectively. Changes in endowment net assets primarily relate to investment returns, contributions, and appropriations for expenditures. CommonSpirit preserves the fair value of these gifts as of the date of donation unless otherwise stipulated by the donor. Donor-restricted endowment funds are classified as net assets with donor restrictions until those amounts are appropriated for expenditure. CommonSpirit considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: (1) the duration and preservation of the fund, (2) the purposes of the organization and the donor-restricted endowment fund, (3) general economic conditions, (4) the possible effect of inflation and deflation, (5) the expected total return from income and the appreciation of investments, (6) other resources of the organization, and (7) the investment policies of CommonSpirit.

CommonSpirit has investment and spending policies for endowment assets designed to provide a predictable stream of funding to programs supported by its endowments while seeking to maintain the purchasing power of the endowment assets.

Endowment assets are invested in a manner that is intended to produce results that achieve the respective benchmark while assuming a moderate level of investment risk. Actual returns in any given year may vary from this amount. To satisfy its long-term rate-of-return objectives, CommonSpirit relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). CommonSpirit targets a diversified asset allocation to achieve its long-term return objectives within prudent risk constraints.

***Special Charges and Other Costs* –** Special charges include costs related to the affiliation of CHI and Dignity Health, changes in business operations, long-lived asset impairments, and pension settlement activity. Changes in business operations include patient information go-live support and costs incurred to implement reorganization efforts within specific operations in order to align CommonSpirit's operations in the most strategic and cost effective manner. See Note 19.

Community Benefits – As part of its mission, CommonSpirit provides services to the poor and benefits for the broader community. The costs incurred to provide such services are included in excess of revenues over expenses in the accompanying consolidated statements of operations and changes in net assets. CommonSpirit prepares a summary of unsponsored community benefit expense in accordance with Internal Revenue Service Form 990, Schedule H, and the Catholic Health Association of the United States ("CHA") publication, *A Guide for Planning and Reporting Community Benefit*. See Note 23.

Interest Expense – Interest expense on debt issued for construction projects is capitalized until the projects are placed in service. Interest expense, net, includes interest and fees on debt, net of these capitalized amounts. See Note 17.

Income Taxes – CommonSpirit has established its status as an organization exempt from income taxes under the Internal Revenue Code Section 501(c)(3) and the laws of the states in which it operates, and as such, is generally not subject to federal or state income taxes. However, CommonSpirit's exempt organizations are subject to income taxes on net income derived from a trade or business, regularly carried on, which does not further the organizations' exempt purposes. No significant income tax provision has been recorded in the accompanying consolidated financial statements for net income derived from unrelated trade or business.

CommonSpirit's for-profit subsidiaries account for income taxes related to their operations. The for-profit subsidiaries recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of their assets and liabilities, along with net operating loss and tax credit carryovers, for tax positions that meet the more-likely-than-not recognition criteria. Changes in recognition or measurement are reflected in the period in which the change in judgment occurs.

Income tax interest and penalties are recorded as income tax expense. For the years ended June 30, 2019 and 2018, CommonSpirit's taxable entities recorded an immaterial amount of interest and penalties as part of the provision for income taxes. CommonSpirit's taxable entities did not have any material unrecognized income tax benefits as of June 30, 2019 and 2018. CommonSpirit reviews its tax positions quarterly and has determined that there are no material uncertain tax positions that require recognition in the accompanying consolidated financial statements.

Performance Indicator – Management considers excess of revenues over expenses to be CommonSpirit's performance indicator. Excess of revenues over expenses includes all changes in net assets without donor restrictions except for the effect of changes in accounting principles, gains and losses from discontinued operations, net assets released from restrictions used for purchase of property and equipment, change in funded status of pension and other postretirement benefit plans, change in ownership interests held by controlled subsidiaries, change in accumulated unrealized derivative gains and losses, and funds donated from unconsolidated sources for purchase of property and equipment.

Operating and Nonoperating Activities **–** CommonSpirit's primary purpose is to provide a variety of health care-related activities, education and other benefits to the communities in which it operates. Activities directly related to the furtherance of this purpose are recorded as operating activities. Other activities outside of this mission are reported as nonoperating activities. Such activities include net investment income, income tax expense, interest cost and changes in fair value of interest rate swaps, contribution gains from affiliations, and the nonoperating component of Joint Operating Agreement ("JOA") income share adjustments.

Recent Accounting Pronouncements – In July 2018, the FASB issued ASU No. 2018-11, *Leases (Topic 842)*, which enhanced ASU No. 2016-02, *Leases (Topic 842)*, and amendments thereto. The guidance of these ASUs requires the rights and obligations arising from the lease contracts, including existing and new arrangements, to be recognized as assets and liabilities on the balance sheet and allows for an option to apply the transition provisions of the new standard at its adoption date instead of at the earliest comparative period presented in its financial statements. The ASUs were effective July 1, 2019, and CommonSpirit has elected the practical expedient to initially apply the new leasing standard at the effective date. CommonSpirit is finalizing its analysis of certain key assumptions that will be utilized at the transition date, including the incremental borrowing rate. The primary effect of the new standard will be to record right-of-use assets and obligations for leases classified as operating leases under current guidance, which will have a material impact on the consolidated balance sheets and significant incremental disclosures in the notes to consolidated financial statements. The standard will not have a material impact on CommonSpirit's consolidated statements of operations or cash flows.

In March 2017, the FASB issued ASU No. 2017-07, *Compensation – Retirement Benefits (Topic 715), Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost*, which requires employers to report the service cost component in the same line item or items as other compensation costs arising from services rendered by the pertinent employees during the period, and the other components of net benefit cost are required to be presented on the income statement separately from the service cost component and outside of income from operations. The guidance is effective for CommonSpirit for the annual period ending June 30, 2020, and interim periods beginning July 1, 2020. The estimated net loss and prior service credit for the pension plans expected to be recognized in net periodic benefit cost during the year ending June 30, 2020, is $67 million. As a result of the adoption of ASU 2017-07, this component of net periodic benefit cost will be reflected in nonoperating income (loss) in the consolidated statements of operations and changes in net assets.

In August 2016, the FASB issued ASU No. 2016-14, *Not-for-Profit Entities (Topic 958), Presentation of Financial Statements of Not-for-Profit Entities*, which requires changes in presentation and disclosures to help not-for-profit entities provide more relevant information about their resources, including liquidity information, to donors, grantors, creditors, and other issues. The most significant change is that net assets are now reported in two classes: net assets without donor restrictions and net assets with donor restrictions. CommonSpirit adopted the guidance as of June 30, 2019, on a retrospective basis for all periods presented. The adoption did not have a material impact on the accompanying consolidated financial statements.

In May 2014, the FASB issued ASU No. 2014-09, *Revenue from Contracts with Customers,* which outlines a single comprehensive model for entities to use in accounting for revenue arising from contracts with customers and supersedes most current revenue recognition guidance, including industry-specific guidance, and requires expanded disclosures about revenue recognition. The core principle of the revenue model is that an entity recognizes 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. CommonSpirit adopted the guidance, as amended by ASU 2015-14, as of July 1, 2018, under the modified retrospective approach applied to all contracts existing as of that date. CommonSpirit primarily used a portfolio approach to apply the new model to classes of customers with similar characteristics. The impact of the

adoption of the new standard on CommonSpirit's 2019 total revenues and results of operations is not material, as the analysis of its contracts under the new guidance supports the recognition of revenue consistent with its prior revenue recognition model. The most significant impact of adopting the new standard is to the presentation of the consolidated statements of operations and changes in net assets, where the provision for doubtful accounts is no longer presented as a separate line item and revenues are presented net of estimated implicit price concession revenue deductions. The related presentation of allowances for uncollectible accounts has been eliminated on the consolidated balance sheets for 2019 as a result of the adoption of the new standard.

Subsequent Events – CommonSpirit has evaluated subsequent events occurring between the end of the most recent fiscal year and October 4, 2019, the date the financial statements were issued. See Notes 3 and 15.

3. ACQUISITIONS, AFFILIATIONS AND DIVESTITURES

Affiliation of CHI and Dignity Health – On February 1, 2019, CHI and Dignity Health effected a business combination as discussed in Note 1. Due to the circumstances of the business combination between CHI and Dignity Health, through the alignment under CHCF, the transaction qualified for acquisition accounting with CommonSpirit Health as the accounting acquirer of Dignity Health. The affiliation was accounted for as an acquisition under Accounting Standards Codification ("ASC") 958-805, *Not-for-Profit Entities – Business Combinations*. No cash consideration was involved in the affiliation. As a result of the affiliation, a contribution of the excess of assets over liabilities of Dignity Health assumed by CommonSpirit of $10 billion was recognized. Of this amount, $9.2 billion was reported as a contribution from business combination within other income (loss) in the accompanying consolidated statements of operations and changes in net assets, and $235 million and $559 million was recorded as contribution from business combination for noncontrolling interest and net assets with donor restrictions, respectively, in the accompanying consolidated statements of operations and changes in net assets.

Dignity Health's assets acquired and liabilities assumed were fair valued using Level 3 inputs. The following summarizes the fair value estimate of Dignity Health's assets acquired and liabilities assumed as of February 1, 2019 (in millions):

Cash and cash equivalents	$	679
Short-term investments		2,425
Patient accounts receivable, net		1,789
Broker receivables for unsettled investment trades		36
Provider fee receivable		1,099
Other current assets		699
Designated assets for capital projects and other		2,746
Designated assets held for self-insured claims		768
Assets held under bond indenture agreements for debt service		4
Donor-restricted		557
Other assets limited as to use		90
Property and equipment, net		7,146
Ownership interests in health-related activities		1,315
Intangible assets, net		516
Other long-term assets, net		44
Long-term debt		(5,246)
Accounts payable		(564)
Accrued salaries and benefits		(719)
Broker payables for unsettled investment trades		(7)
Provider fee payables		(347)
Self-insured reserves and claims		(721)
Pension and other postretirement benefit liabilities		(1,640)
Derivative instruments		(140)
Other accrued liabilities		(527)
Total contribution of net assets	$	10,002

The following summarizes the financial results of Dignity Health included in the accompanying consolidated financial statements from the date of the affiliation through June 30, 2019 (in millions):

Total operating revenues	$	5,839
Operating income		117
Excess of revenues over expenses		372

The following unaudited pro forma consolidated financial information of CommonSpirit for 2019 and 2018 has been derived by CommonSpirit management from the results of CHI and Dignity Health assuming that operations of the two organizations were combined as of July 1, 2017. Acquisition-related adjustments have been excluded from the pro forma results.

(in millions)	2019 Actual	2019 Pro Forma (a)	2018 Actual	2018 Pro Forma (b)
Operating revenues:				
Net patient revenue	$ 19,476	$ 26,570	$ 14,136	$ 26,820
Premium revenue	476	1,034	53	955
Revenue from health-related activities, net	70	104	18	145
Other operating revenue	897	1,090	733	1,222
Contributions	47	63	42	62
Total operating revenues	20,966	28,861	14,982	29,204
Operating expenses:				
Salaries and benefits	10,161	14,154	7,111	14,071
Supplies	3,337	4,519	2,449	4,422
Purchased services and other	6,273	8,495	4,379	8,365
Depreciation and amortization	1,087	1,423	856	1,458
Interest expense, net	391	492	313	472
Total operating expenses	21,249	29,083	15,108	28,788
Operating income (loss) before special charges and other costs	(283)	(222)	(126)	416
Special charges and other costs	(319)	(360)	(141)	(172)
Operating gain (loss)	(602)	(582)	(267)	244
Nonoperating income (loss):				
Investment income, net	612	558	443	891
Income tax expense	(14)	(23)	(10)	1
Change in fair value and cash payments of interest rate swaps	(131)	(150)	52	70
Contribution (loss) from business combination, net	9,155	(53)	-	-
Other	(6)	(4)	4	4
Total nonoperating income, net	9,616	328	489	966
Excess (deficit) of revenues over expenses	$ 9,014	$ (254)	$ 222	$ 1,210
Less excess of revenues over expenses attributable to noncontrolling interests	6	36	28	84
Excess (deficit) of revenues over expenses attributable to CommonSpirit	$ 9,008	$ (290)	$ 194	$ 1,126

(a) Includes the historical results of Dignity Health for the seven-month period ended January 31, 2019, prior to the affiliation.

(b) Includes the historical results of Dignity Health for the year ended June 30, 2018, prior to the affiliation.

KentuckyOne Health – In July 2017, in accordance with an agreement entered into in December 2016 between KentuckyOne Health and University Medical Center ("UMC"), UMC took over the management of its assets and CHI ceased consolidating the UMC operations as part of KentuckyOne Health. The transaction resulted in a loss on deconsolidation of $319 million in 2018, reflected in discontinued operations in the accompanying consolidated statement of operations and changes in net assets.

In September 2017, CHI became the sole owner of KentuckyOne Health through the purchase of the noncontrolling interest from the remaining partner for $150 million in cash consideration.

QualChoice Health, Inc. – In January 2019, CHI sold QualChoice Health Inc.'s ("QualChoice Health") Medicare Advantage health insurance contract rights in the state of Washington. The purchase price is contingent upon future increases in the number of lives covered by the Medicare Advantage plans acquired and upon maintaining a specified Centers for Medicare & Medicaid Services ("CMS") Star Rating as published annually in October 2018 and 2019. As of June 30, 2019, QualChoice Health has recognized $14 million in proceeds from the sale.

In April 2019, CHI sold the commercial insurance operations of QualChoice Health in the state of Arkansas for gross proceeds of $46 million.

Jewish Hospital and St. Mary's Healthcare, Inc. – In May 2017, CHI approved a plan to sell or otherwise dispose of certain entities of Jewish Hospital and St. Mary's Healthcare, Inc. ("JHSMH"). In December 2017, CHI entered into a nonbinding letter of intent to negotiate a definitive agreement for the purchase of substantially all of the JHSMH assets. As of December 31, 2017, and as a result of the anticipated sale transaction, the assets and liabilities of the JHSMH discontinued operations were remeasured at the lower of their carrying amount or their fair value less cost to sell, which resulted in the recognition of an impairment charge of $272 million in the accompanying consolidated statements of operations and changes in net assets.

In June 2018, an updated letter of intent for the purchase of JHSMH was received and, based upon the terms of that letter of intent, CHI recognized additional impairment charges of $106 million in discontinued operations and $12 million in continuing operations to adjust the JHSMH property and equipment values to the lower of their carrying value or their fair value less cost to sell.

In August 2019, an Asset Purchase Agreement was signed with parties related to the University of Louisville for the purchase of the JHSMH operations held for sale. The closing of the transaction is expected to occur on October 31, 2019, with an effective date of November 1, 2019, pending usual and customary closing conditions.

Premier Health Partners – In January 2018, CHI effected an agreement with Premier Health Partners ("Premier"), an Ohio nonprofit corporation operating various hospitals in southwest Ohio, to reorganize and restructure the existing joint operating agreement with Premier. The agreement provided that CHI transfer ownership of Good Samaritan-Dayton ("Dayton") to Premier in exchange for a 22% interest in Premier. No gain or loss was recognized upon the exchange as the net book value of Dayton was equal to the fair value of the interest received in Premier of $325 million.

4. ASSETS AND LIABILITIES HELD FOR SALE

A summary of major classes of assets and liabilities held for sale is presented below as of June 30 (in millions):

Assets	2019	2018
Patient accounts receivable, net	$ 124	$ -
Other accounts receivable	16	24
Held for self-insurance claims	47	127
Other assets	26	31
Property and equipment, net	9	7
Other long-term assets	1	7
Total assets held for sale	$ 223	$ 196

Liabilities	2019	2018
Current portion of long-term debt	$ -	$ 9
Accounts payable	58	27
Accrued salaries and benefits	43	42
Other accrued liabilities	20	39
Self-insured reserves and claims	7	91
Other long-term liabilities	34	44
Total liabilities held for sale	$ 162	$ 252

Operating results of discontinued operations are reported in the accompanying consolidated statements of operations and changes in net assets and are summarized as follows for the years ended June 30 (in millions):

	2019	2018
Net patient revenue	$ 703	$ 713
Other operating revenue	419	582
Total operating revenues	1,122	1,295
Salaries and benefits	427	440
Purchased services and other	727	917
Depreciation and amortization	3	4
Total operating expenses	1,157	1,361
Operating loss before special charges and other	(35)	(66)
Special charges and other	(40)	(724)
Operating loss	(75)	(790)
Nonoperating loss	(4)	(3)
Deficit of revenues over expenses	(79)	(793)
Deficit of revenues over expenses attributable to noncontrolling interests	-	(3)
Deficit of revenues over expenses attributable to CommonSpirit Health	$ (79)	$ (790)

In 2018, discontinued operations include impairment charges totaling $378 million for JHSMH and a $319 million loss on deconsolidation of UMC.

5. NET PATIENT REVENUE

The percentage of inpatient and outpatient services, calculated on the basis of usual and customary charges, is as follows for the year ended June 30:

	2019	2018
Inpatient services	48%	44%
Outpatient services	52%	56%

Patient revenue, net of contractual discounts and adjustments and implicit price concessions, is comprised of the following for the year ended June 30 (in millions):

	2019	2018
Government	$ 9,676	$ 6,587
Contracted	8,236	6,036
Self-pay and other	1,564	1,513
	$ 19,476	$ 14,136

Government payor type includes Medicare fee for service, Medicare capitated, Medicare managed care fee for service, Medicaid fee for service, Medicaid capitated and Medicaid managed care fee for service patient accounts. Contracted payor type includes contracted rate payors and commercial capitated patient accounts.

Total operating revenues by service line is as follows:

	2019	2018
Hospitals	$ 17,167	$ 12,040
Physician organizations	2,277	1,772
Long-term care and home care	324	324
Other	184	53
Net patient and premium revenue	19,952	14,189
Health plans, accountable care, and other	1,014	793
Total operating revenue	$ 20,966	$ 14,982

The increase in total operating revenue in 2019 relates to the affiliation with Dignity Health. See Note 1.

6. OTHER CURRENT ASSETS

Other current assets consist of the following at June 30 (in millions):

	2019	2018
Inventories	$ 538	$ 299
Receivables, other than patient accounts receivable	522	205
Prepaid expenses	286	137
Other	57	1
Total other current assets	$ 1,403	$ 642

7. INVESTMENTS AND ASSETS LIMITED AS TO USE

Investments and assets limited as to use include assets set aside by CommonSpirit for future long-term purposes, including capital improvements and self-insurance for workers' compensation and professional and general liabilities, funds held by trustees under bond indenture agreements, amounts contributed by donors with stipulated restrictions, and amounts held for mission and ministry programs. Amounts set aside consist of the following at June 30 (in millions):

	2019	2018
Cash and short-term investments	$ 697	$ 112
U.S. government securities	843	200
U.S. corporate bonds	941	215
U.S. equity securities	1,372	269
Foreign government securities	-	83
Foreign corporate bonds	153	-
Foreign equity securities	1,302	-
Asset-backed securities	-	121
Private equity investments	643	-
Multi-strategy hedge fund investments	1,179	-
Real estate	233	-
CHI Operating Investment Program	4,738	5,534
Other	459	150
Interest in net assets of unconsolidated foundations	328	-
Total	$ 12,888	$ 6,684
Assets limited as to use:		
Current	$ 2,315	$ 218
Long-term	8,062	6,466
Short-term investments	2,511	-
Total	$ 12,888	$ 6,684

The current portion of assets limited as to use includes the amount of assets available to meet current obligations for debt service and claims payments under the self-insured programs for workers' compensation for employees and professional and general liability, and the current portion of pledges receivable.

8. FAIR VALUE MEASUREMENTS

CommonSpirit accounts for certain assets and liabilities at fair value or on a basis that approximates fair value. A fair value hierarchy for valuation inputs categorizes the inputs into three levels based on the extent to which inputs used in measuring fair value are observable in the market. Each fair value measurement is reported in one of the three levels and is determined by the lowest level input that is significant to the fair value measurement in its entirety. These levels are:

Level 1: Quoted prices are available in active markets for identical assets or liabilities as of the measurement date. Financial assets in this category include money market funds, U.S. Treasury securities and listed equities.

Level 2: Pricing inputs are based upon quoted prices for similar instruments in active markets, quoted prices for identical or similar instruments in markets that are not active, and model-based valuation techniques for which all significant assumptions are observable in the market or can be corroborated by observable market data for substantially the full term of the assets or liabilities. Financial assets and liabilities in this category generally include asset-backed securities, corporate bonds and loans, municipal bonds, and derivative instruments.

Level 3: Pricing inputs are generally unobservable for the assets or liabilities and include situations where there is little, if any, market activity for the investment. The inputs into the determination of fair value require management's judgment or estimation of assumptions that market participants would use in pricing the assets or liabilities. The fair values are therefore determined using model-based techniques that include option pricing models, discounted cash flow models, and similar techniques.

The following represents assets and liabilities measured at fair value or at the NAV practical expedient on a recurring basis and certain other assets accounted for under the equity method as of June 30 (in millions):

	2019			
	Quoted Prices in Active Markets for Identical Instruments (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Assets				
Cash and short-term investments	$ 630	$ 67	$ -	$ 697
U.S. government securities	727	116	-	843
U.S. corporate bonds	71	440	-	511
U.S. equity securities	1,147	12	-	1,159
Foreign equity securities	629	2	-	631
Private equity	-	-	65	65
Other investments	61	25	1	87
Assets measured at fair value	$ 3,265	$ 662	$ 66	3,993
Assets at NAV:				
U.S. corporate bonds				430
U.S. equity securities				213
Foreign corporate bonds				153
Foreign equity securities				671
Private equity				578
Hedge funds				1,179
Real estate				233
Total assets				$ 7,450
Liabilities				
Derivative instruments	$ -	$ 454	$ -	$ 454
Other	3	-	74	77
Total liabilities	$ 3	$ 454	$ 74	$ 531

	2018			
	Quoted Prices in Active Markets for Identical Instruments (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Assets				
Cash and short-term investments	$ 102	$ 10	$ -	$ 112
U.S. government securities	185	15	-	200
U.S. corporate bonds	-	215	-	215
U.S. equity securities	267	2	-	269
Foreign government securities	-	83	-	83
Asset-backed securities	-	121	-	121
Other investments	-	2	3	5
Total assets	$ 554	$ 448	$ 3	$ 1,005
Liabilities				
Derivative instruments	$ -	$ 208	$ -	$ 208
Other	5	-	82	87
Total liabilities	$ 5	$ 208	$ 82	$ 295

Assets and liabilities measured at fair value on a recurring basis reflected in the table above are reported in short-term investments, assets limited as to use, current liabilities and other liabilities in the accompanying consolidated balance sheets.

There were no transfers among any of the levels of fair value hierarchy during the periods presented.

The Level 2 and 3 instruments listed in the fair value hierarchy tables above use the following valuation techniques and inputs:

For marketable securities, such as U.S. and foreign government securities, U.S. and foreign corporate bonds, U.S. and foreign equity securities, mortgage and asset-backed securities, and structured debt, in the instances where identical quoted market prices are not readily available, fair value is determined using quoted market prices and/or other market data for comparable instruments and transactions in establishing prices, discounted cash flow models and other pricing models. These inputs to fair value are included in industry-standard valuation techniques, such as the income or market approach. CommonSpirit classifies all such investments as Level 2.

For private equity investments where no fair value is readily available, the fair value is determined using models that take into account relevant information considered material. Due to the significant unobservable inputs present in these valuations, CommonSpirit classifies all such investments as Level 3.

The fair value of collateral held under securities lending program is classified as Level 2. The collateral held under this program is placed in commingled funds whose underlying investments are valued using techniques similar to those used for the marketable securities noted above. Amounts reported do not include non-cash collateral of $54 million and $0 million as of June 30, 2019 and 2018, respectively.

The fair value of assets and liabilities for derivative instruments, such as interest rate swaps classified as Level 2, is determined using an industry standard valuation model, which is based on a market approach. A credit risk spread (in basis points) is added as a flat spread to the discount curve used in the valuation model. Each leg is discounted and the difference between the present value of each leg's cash flows equals the fair value of the swap.

Investments that are measured using the NAV per share practical expedient have not been classified in the fair value hierarchy. The NAV amounts presented in the table above are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the balance sheet.

Related to investments valued using the NAV per share practical expedient, management also performs, on a regular basis when information is available, various validations and testing of NAV provided and determines that the investment managers' valuation techniques are compliant with fair value measurement accounting standards.

Financial assets totaling $65 million were transferred to Level 3 through the contribution from business combination. See Note 3.

The following table and explanations identify attributes relating to the nature and risk of investments for which fair value is determined using a calculated NAV as of June 30, 2019 (in millions):

		As of June 30, 2019			
		NAV Practical Expedient	**Unfunded Commitments**	**Redemption Frequency (If Currently Eligible)**	**Redemption Notice Period**
Private equity	(1)	$ 578	$ -	-	-
Multi-strategy hedge funds	(2)	1,179	-	Monthly, Quarterly, Semi-annually, Annually	5 - 120 days
Real estate	(3)	233	10	Quarterly	90 days
Commingled funds - debt securities	(4)	583	41	Daily, Monthly, Quarterly	1 - 90 days
Commingled funds - equity securities	(5)	884	-	Daily, Monthly, Quarterly	1 - 90 days
Total		$ 3,457	$ 51		

(1) This category includes private equity funds that specialize in providing capital to a variety of investment groups, including, but not limited to, venture capital, leveraged buyout, mezzanine debt, distressed debt, and other situations. There are no provisions for redemptions during the life of these funds. Distributions from each fund will be received as the underlying investments of the funds are liquidated, estimated at June 30, 2019, to be over the next 11 years.

(2) This category includes investments in hedge funds that pursue diversification of both domestic and foreign fixed income and equity securities through multiple investment strategies. The primary objective for these funds is to seek attractive long-term, risk-adjusted absolute returns. Under certain circumstances, an otherwise redeemable investment or portion thereof could become restricted. The following table reflects the various redemption frequencies, notice periods, and any applicable lock-up periods or gates to redemption as of June 30, 2019:

Percentage of the Value of Category (2)			Redemption	Redemption	Redemption
Total	Subtotal	Redemption Frequency	Notice Period	Locked Up Until (if applicable)	Gate % of Account (if applicable)
7.4%	6.0%	Annually	60 days	2 years	up to 50.0%
	1.4%	Annually	75 days	-	-
8.8%	5.4%	Semi-annually	60 days	-	up to 25.0%
	3.4%	Semi-annually	75 - 90 days	2 years	-
51.1%	9.1%	Quarterly	30 - 45 days	2 years	up to 20.0%
	30.8%	Quarterly	60 - 65 days	1 year	up to 12.5% - 25.0%
	11.2%	Quarterly	90 days	-	up to 12.5% - 25.0%
32.7%	11.7%	Monthly	5 - 20 days	-	-
	12.7%	Monthly	30 - 45 days	-	up to 16.7%
	8.3%	Monthly	60 - 120 days	6 months	up to 20.0%

(3) This category includes investments in real estate funds that invest primarily in institutional-quality commercial and residential real estate assets within the U.S. and investments in publicly traded real estate investment trusts. Investments representing 16% of the value of investments in this category do not have provisions for redemptions during the life of these funds. Distributions will be received as the underlying investments of the funds are liquidated, estimated at June 30, 2019, to be over the next six years.

(4) This category includes investments in commingled funds that invest primarily in domestic and foreign debt and fixed income securities, the majority of which are traded in over-the-counter markets. Also included in this category are commingled fixed income funds that provide capital in a variety of mezzanine debt, distressed debt and other special debt securities situations. Investments representing approximately 9% of the value of investments in this category do not have provisions for redemptions during the life of these funds. Distributions will be received as the underlying investments of the funds are liquidated, estimated at June 30, 2019, to be over the next six years.

(5) This category includes investments in commingled funds that invest primarily in domestic or foreign equity securities with multiple investment strategies. A majority of the funds attempt to match or exceed the returns of specific equity indices.

The investments included above are not expected to be sold at amounts that are materially different from NAV.

CHI's investment portfolio is held directly by the CHI Operating Investment Program, L.P. (the "Program"). The Program is structured under a limited partnership agreement with CHI as managing general partner and numerous limited partners, most sponsored by CHI. The partnership provides a vehicle whereby virtually all entities associated with CHI, as well as certain other unrelated entities, can optimize investment returns while managing investment risk. Limited partners may make deposits into the Program on the first business day of each month. Withdrawals may be made from the Program on the first business day of each month upon five business days' prior notice. Fulfillment of withdrawal requests may be delayed due to market restrictions or other conditions as determined by CHI. Withdrawal requests will be fulfilled as soon as practical based upon the conditions necessitating the delay, with at least 25% of the amount requested fulfilled within 60 days, the next 25% within 90 days, and the remaining 50% within 180 days. The entire withdrawal request shall be fulfilled within 180 days of the date such request was made. The limited partnership agreement permits a simple-majority vote of the noncontrolling limited partners to terminate the partnership. Accordingly, CHI recognizes only the utilized portion of Program assets attributable to CHI and its direct affiliates in which it has sole corporate membership or ownership, accounting for its ownership in the Program under the equity method. As such, these investments are excluded from the scope of fair value measurements reported above.

Certain of the Program's alternative investments are made through limited liability companies ("LLCs") and limited liability partnerships ("LLPs"). These LLCs and LLPs provide the Program with a proportionate share of the investment gains or losses. The Program accounts for its ownership in the LLCs and LLPs under the equity method.

The Program's alternative investments are not publicly traded and readily available market quotations are generally not available to be used for valuation purposes. Accordingly, the Program's alternative investments are measured at NAV as of the reporting date, as reported by fund managers, and are excluded from the three-level hierarchy for fair value measurements.

While the Program believes that its valuation methods are appropriate and consistent with those used by other market participants, the use of different methodologies or assumptions to estimate the fair value of Level 3 investments could result in a different estimate of fair value at the reporting date. Level 3 fair value estimates and Alternative Investments measured at NAV may differ significantly from the values that would have been determined had a readily available market for such investments existed, or had such investments been liquidated or sold to external investors, and these differences could be material to the Program's financial statements.

In situations where inputs used to determine fair value fall into different levels of the fair value hierarchy, the level within the fair value hierarchy is based on the lowest level of input that is significant to the fair value measurement.

The following represents assets and liabilities of the Program in its entirety, of which CHI holds 89% as of June 30, 2019 and 2018, measured at fair value or at the NAV practical expedient on a recurring basis and certain other assets accounted for under the equity method as of June 30 (in millions):

	2019			
	Quoted Prices in Active Markets for Identical Instruments (Level 1)	**Significant Other Observable Inputs (Level 2)**	**Significant Unobservable Inputs (Level 3)**	**Total**
Assets				
Short-term investments	$ 321	$ 77	$ -	$ 398
Common stocks	2,100	-	-	2,100
Mutual funds and exchange-traded funds	97	-	-	97
Preferred stocks	5	9	-	14
Fixed-income funds	-	417	-	417
Corporate bonds	-	314	-	314
Asset-backed securities	-	347	-	347
U.S. government bonds:				
U.S. treasury inflation indexed bonds	23	-	-	23
U.S. treasury notes	57	-	-	57
Other	-	8	-	8
Foreign government bonds	-	64	-	64
CHI Direct Community Investment Program	-	-	55	55
Foreign currency exchange contracts	-	220	-	220
Term loans	-	-	192	192
Assets measured at fair value	$ 2,603	$ 1,456	$ 247	4,306
Assets at NAV:				
Hedge funds				524
Real estate				427
Venture capital/private equity				351
Total assets				$ 5,608
Liabilities - foreign currency exchange contracts	$ -	$ 220	$ -	$ 220

	2018			
	Quoted Prices in Active Markets for Identical Instruments (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Assets				
Short-term investments	$ 229	$ 120	$ -	$ 349
Common stocks	2,399	-	-	2,399
Mutual funds and exchange-traded funds	333	-	-	333
Preferred stocks	5	7	-	12
Fixed-income funds	-	668	-	668
Corporate bonds	-	421	-	421
Asset-backed securities	-	478	-	478
U.S. government bonds:				
U.S. treasury inflation indexed bonds	14	-	-	14
U.S. treasury notes	150	-	-	150
Other	-	21	-	21
Foreign government bonds	-	73	-	73
CHI Direct Community Investment Program	-	-	54	54
Foreign currency exchange contracts	-	207	-	207
Term loans	-	-	193	193
Assets measured at fair value	$ 3,130	$ 1,995	$ 247	5,372
Assets at NAV:				
Hedge funds				523
Real estate				397
Venture capital/private equity				334
Total assets				$ 6,626
Liabilities - foreign currency exchange contracts	$ -	$ 208	$ -	$ 208

9. PROPERTY AND EQUIPMENT, NET

Property and equipment, net, consists of the following at June 30 (in millions):

	2019	2018
Land and improvements	$ 1,879	$ 759
Buildings	11,290	7,162
Equipment	8,666	6,945
Construction in progress	1,685	656
Total	23,520	15,522
Less: Accumulated depreciation	(8,254)	(7,411)
Property and equipment, net	$ 15,266	$ 8,111

10. OWNERSHIP INTERESTS IN HEALTH-RELATED ACTIVITIES

Joint Operating Agreements – CommonSpirit participates in JOAs with hospital-based organizations in three separate market areas. The agreements generally provide for, among other things, joint management of the combined operations of the local facilities included in the JOAs through Joint Operating Companies ("JOCs"). CommonSpirit retains ownership of the assets, liabilities, equity, revenues and expenses of the CommonSpirit facilities that participate in the JOAs. The financial statements of the CommonSpirit facilities managed under all JOAs are included in the accompanying consolidated financial statements. Transfers of assets from facilities owned by the JOA participants generally are restricted under the terms of the agreements.

As of June 30, 2019 and 2018, CommonSpirit has investment interests of 65%, 50% and 50% in JOCs based in Colorado, Iowa, and Ohio, respectively. CommonSpirit's interests in the JOCs are included in ownership interests in health-related activities in the accompanying consolidated balance sheets and totaled $450 million and $436 million at June 30, 2019 and 2018, respectively. CommonSpirit recognizes its investment in all JOCs under the equity method of accounting. The JOCs provide varying levels of services to the related JOA sponsors, and operating expenses of the JOCs are allocated to each sponsoring organization.

Other Ownership Interests in Health-Related Activities – In addition to the JOCs above, CommonSpirit has significant ownership interests, as further described below, that are accounted for under the equity method and reflected in the accompanying consolidated balance sheet in ownership interests in health-related activities:

- CHI acquired the investment in Conifer Health Solutions ("Conifer") in May 2012 as part of a multi-year agreement whereby Conifer provides revenue cycle services and health information management solutions for CHI's acute care operations. CommonSpirit's ownership interest in Conifer was 23.8% as of June 2019 and 2018.
- In January 2018, CHI entered into an agreement with Premier to reorganize and restructure the existing JOA with Premier. The agreement provided that CHI transfer ownership of the Dayton market-based organization to Premier in exchange for a 22% interest in Premier.
- Dignity Health transferred and contributed to Optum360, LLC ("Optum360º") certain equipment and the intellectual property related to its internal revenue cycle management functions for a noncontrolling interest in Optum360° in September 2013. Optum360° also provides revenue cycle management functions for other health care organizations. CommonSpirit's ownership interest in Optum360º was 23% at June 30, 2019.
- Dignity Health contributed the stock of U.S. HealthWorks to Concentra, Inc. in February 2018 to strengthen the access and delivery of expanded occupational care for employees, payors, and patients. Pursuant to the transaction, Dignity Health received a 20.6% interest in the combined entity, Concentra Group Holdings Parent, LLC.

The following table summarizes the financial position and results of operations for the significant health-related activities discussed above, which are accounted for under the equity method, as of and for the 12 months ended June 30, or portion of the periods thereof while held by CommonSpirit (in millions):

	2019			
	Hospitals	JOCs	Other	Total
Total assets	$ 2,646	$ 1,418	$ 5,763	$ 9,827
Total liabilities	1,415	585	2,402	4,402
Total net assets	1,231	833	3,343	5,407
Total operating revenues, net	1,861	957	2,380	5,198
Excess (deficit) of revenues over expenses	(131)	(142)	302	29
Investment at June 30 recorded in ownership interests in health-related activities	270	450	1,397	2,117
Income (loss) recorded in revenue from health-related activities, net	(31)	(63)	105	11

	2018			
	Hospitals	JOCs	Other	Total
Total assets	$ 2,729	$ 1,365	$ 1,310	$ 5,404
Total liabilities	1,334	599	281	2,214
Total net assets	1,395	766	1,029	3,190
Total revenues, net	1,733	927	1,525	4,185
Excess (deficit) of revenues over expenses	(167)	(127)	304	10
Investment at June 30 recorded in ownership interests in health-related activities	311	436	671	1,418
Income (loss) recorded in revenue from health-related activities, net	(15)	(61)	57	(19)

Other than the investments described above, ownership interests totaling $1 billion are not material individually to the consolidated financial statements.

11. GOODWILL

Goodwill is measured as of the effective date of a business combination as the excess of the aggregate of the fair value of consideration transferred over the fair value of the tangible and intangible assets acquired and liabilities assumed.

The changes in the carrying amount of goodwill are as follows (in millions):

	2019	2018
Balance at beginning of period	$ 239	$ 232
Addition from acquisitions	3	11
Goodwill divested during the year	-	(4)
Balance at end of period	$ 242	$ 239

12. INTANGIBLE ASSETS, NET

Intangible assets, net, consist of the following at June 30 (in millions):

	2019			
	Gross Carrying Amount	Accumulated Amortization	Net Balance at End of Period	Amortization period
Trademarks	$ 555	$ -	$ 555	Indefinite
Trademark agreements	156	(42)	114	120 - 300 months
Noncompete agreements	11	(8)	3	24 months
Certificate of need	13	-	13	Indefinite
Other contracts	39	(10)	29	150 - 168 months
	$ 774	$ (60)	$ 714	

	2018			
	Gross Carrying Amount	Accumulated Amortization	Net Balance at End of Period	Amortization period
Trademarks	$ 10	$ -	$ 10	Indefinite
Trademark agreements	161	(35)	126	120 - 300 months
Noncompete agreements	11	(7)	4	60 months
Certificate of need	13	-	13	Indefinite
Other contracts	37	(8)	29	36 - 150 months
	$ 232	$ (50)	$ 182	

The aggregate amortization expense related to intangible assets is $10 million and $9 million for the years ended June 30, 2019 and 2018, respectively, and is recorded in depreciation and amortization on the accompanying consolidated statements of operations and changes in net assets.

Estimated amortization expense related to intangible assets is $9 million in 2020, 2021, 2022 and 2023, $8 million in 2024, and $102 million thereafter.

13. OTHER LONG-TERM ASSETS, NET

Other long-term assets, net, consist of the following at June 30 (in millions):

	2019	2018
Notes receivable, primarily secured	$ 68	$ 52
Other	126	81
Total other long-term assets, net	$ 194	$ 133

14. OTHER ACCRUED LIABILITIES

Other accrued liabilities consist of the following at June 30 (in millions):

	2019	2018
Accrued interest expense	$ 105	$ 76
Due to government agencies	109	118
Capitation claims	82	-
Construction retention and contracts payable	44	-
Liabilities due to medical groups and physicians	71	-
Due to unconsolidated affiliates	116	53
Other	663	554
Total other accrued liabilities	$ 1,190	$ 801

15. DEBT

Notwithstanding the consolidation of the financial statements as of February 1, 2019, as of June 30, 2019, the indebtedness of CHI and Dignity Health remain the separate legal obligations of the respective organizations, until such existing debt is restructured and consolidated into a single credit (the "Debt Consolidation"). The existing debt of CHI upon the affiliation date, the majority of which is evidenced by obligations issued by the Corporation under its Capital Obligation Document (the "COD"), has not been modified, and the Corporation remains the obligor. The existing debt of Dignity Health upon the affiliation date, the majority of which is secured by and subject to the provisions of the Dignity Health Master Trust Indenture (the "Master Trust Indenture"), has not been modified, and the members of the Obligated Group established under the Master Trust Indenture (the "Dignity Health Obligated Group") remain as the obligors.

Master Trust Indenture – As part of a system-wide corporate financing plan, Dignity Health established the Dignity Health Obligated Group to access the capital markets and make loans to its members. Dignity Health Obligated Group members are jointly and severally liable for the obligations outstanding under the Master Trust Indenture. None of the other CommonSpirit subordinate corporations and subsidiaries have assumed any financial obligation related to payment of debt service on obligations issued under the Master Trust Indenture. The Master Trust Indenture requires, among other things, gross revenue of the Dignity Health Obligated Group pledged as collateral, certain limitations on additional indebtedness, liens on property and dispositions or transfers of assets, and the maintenance of certain financial ratios. The Dignity Health Obligated Group is in compliance with these requirements at June 30, 2019.

Capital Obligation Document – The majority of CHI's debt is evidenced with obligations issued under the COD and CHI is the sole obligor. Bondholder security resides in both the COD's unsecured promise by CHI to pay its obligations and the requirement that CHI cause each Participant and Designated Affiliate to pay or otherwise transfer to CHI such amounts as are necessary to make all payments required under the COD when due. Covenants under the COD include a minimum debt service coverage ratio and certain limitations on liens, merger, consolidation, sale and conveyance of CHI's property. CHI has covenanted under the COD to cause its Participants and Designated Affiliates to comply with certain covenants related to corporate existence, maintenance of insurance and operation of their facilities. CHI is in compliance with these requirements as of June 30, 2019.

CommonSpirit Health MTI – As part of the Debt Consolidation plan and in connection with the issuance and sale of the 2019 tax-exempt and taxable bonds, the debt previously issued by CHI and Dignity Health was consolidated into a single unified credit group and debt structure as of August 21, 2019. See "2019 Financing Activity" for additional information.

As of August 21, 2019, the COD and the Master Trust Indenture were amended and restated, both to be the new CommonSpirit Health Master Trust Indenture (the "CommonSpirit Health MTI"), with CHI and the Dignity Health Obligated Group each obtaining the necessary consents. The CommonSpirit Health MTI has an Obligated Group that is comprised of the former Dignity Health Obligated Group and CHI entities (collectively,

the "CommonSpirit Obligated Group"). The CommonSpirit Health Obligated Group represents approximately 92% of consolidated revenues of CommonSpirit as of June 30, 2019.

Debt, net of unamortized debt issuance costs, consists of the following at June 30 (in millions):

	2019	2018
Under master trust indentures and COD:		
Fixed rate debt:		
Fixed rate revenue bonds payable in installments through 2045; interest at 1.88% to 7.0%	$ 4,175	$ 2,926
Fixed rate taxable bonds payable in installments through 2065; interest at 2.6% to 5.3%	2,994	1,790
Total fixed rate debt	7,169	4,716
Variable rate debt:		
Taxable direct placement loans payable in 2019 and 2023; interest set at prevailing market rates (3.29% to 3.32% at June 30, 2019)	353	-
Taxable direct purchase bonds with mandatory tender from 2019 through 2021; interest set at prevailing market rates (3.81% to 4.19% at June 30, 2019)	925	650
Direct purchase bonds payable in installments through 2024; interest set at prevailing market rates (2.53% to 4.43% at June 30, 2019)	922	928
Floating rate notes payable with mandatory tender from 2020 through 2025; interest set at prevailing market rates (2.56% to 3.3% at June 30, 2019)	411	411
Variable rate demand bonds payable in installments through 2047; interest set at prevailing market rates (1.47% to 2.1% at June 30, 2019)	820	97
Auction rate certificates payable in installments through 2042; interest set at prevailing market rates (1.89% to 2.35% at June 30, 2019)	240	-
Bank lines of credit maturing in 2019, 2020 and 2023; interest set at prevailing market rates (2.88% to 3.24% at June 30, 2019)	1,195	250
Commercial paper notes with maturities ranging from 2 to 94 days in 2019; interest set at prevailing market rates (2.65% to 2.9% at June 30, 2019)	881	881
Total variable rate debt	5,747	3,217
Total debt under master trust indentures and COD	12,916	7,933
Other:		
Various notes payable and other debt payable in installments through 2042; interest ranging up to 9.73%	435	480
Capitalized lease obligations	156	113
Total debt	13,507	8,526
Less amounts classified as current	(3,475)	(2,087)
Less demand bonds subject to short-term liquidity arrangements	(820)	(97)
Total long-term debt	$ 9,212	$ 6,342

Scheduled principal debt payments, net of discounts and considering obligations subject to short-term liquidity arrangements as due according to their long-term amortization schedule, for the next five years and thereafter, are as follows (in millions):

	Long-Term Debt Other Than Demand Bonds	Demand Bonds Subject to Short-Term Liquidity Arrangements	Total Long-Term Debt
2020	$ 3,475	$ 97	$ 3,572
2021	169	-	169
2022	175	-	175
2023	1,305	-	1,305
2024	642	-	642
Thereafter	6,921	723	7,644
Total	$ 12,687	$ 820	$ 13,507

***Debt Arrangements* - Fixed Rate Revenue Bonds** – CommonSpirit has fixed rate revenue bonds outstanding, substantially all of which may be redeemed, in whole or in part, prior to the stated maturities without a premium.

Fixed Rate Taxable Bonds – CommonSpirit has taxable fixed rate bonds that are due in November 2019, 2022, 2024, 2042, and 2064, and in August 2023. Early redemption of the debt, in whole or in part, may require a premium depending on market rates.

Taxable Direct Placement Loans – CommonSpirit has nine taxable direct placement loans with six banks at variable interest rates.

Taxable Commercial Paper – CommonSpirit has a commercial paper program that permits the issuance of up to $881 million in aggregate principal amount outstanding, with maturities limited to 270-day periods. As of June 30, 2019, $881 million of commercial paper notes were outstanding. A portion of the notes were refinanced as part of the Debt Consolidation.

Floating Rate Notes – CommonSpirit has floating rate notes ("FRNs") that bear interest at variable rates determined weekly and monthly. These FRNs are subject to mandatory tender on pre-determined dates.

Variable Rate Direct Purchase Bonds – CommonSpirit has variable rate direct purchase bonds placed directly with holders that bear interest at variable rates determined monthly based upon a percentage of the London Inter-bank Offered Rate ("LIBOR") and the Securities Industry and Financial Markets Association ("SIFMA"), plus a spread. These bonds are subject to mandatory tender on pre-determined dates.

Variable Rate Demand Bonds – Variable rate demand bonds ("VRDBs") are remarketed weekly and may be put at the option of the holders. CommonSpirit maintains bank letters of credit of $723 million as credit enhancement for the VRDBs to ensure the availability of funds to purchase any bonds tendered that the remarketing agent is unable to remarket.

Letters of credit to support certain VRDBs of $196 million, $57 million, $90 million, $91 million, $140 million and $150 million expire in October 2019, December 2019, March 2020, June 2021, October 2021, and November 2021, respectively.

CommonSpirit Health has $97 million of additional VRDBs that are self-funded and not supported by letters of credit.

Auction Rate Certificates – CommonSpirit has $240 million of auction rate certificates ("ARCs") that are remarketed weekly. The certificates are insured. Holders of ARCs are required to hold the certificates until the

remarketing agent can find a new buyer for any tendered certificates. The ARCs are insured by Assured Guaranty.

Notes Payable to Banks Under Credit Agreements – In 2019, CommonSpirit maintained a $900 million syndicated line of credit facility for working capital, letters of credit, capital expenditures and other general corporate purposes. The amount outstanding under the syndicated credit facility was $296 million as of June 30, 2019. During 2019, the maximum amount outstanding was $306 million. There were no letters of credit issued under this facility as of June 30, 2019. This credit facility expires in June 2023. Outstanding amounts were refinanced as part of the Debt Consolidation.

CommonSpirit maintained a fully drawn $250 million line of credit expiring in July 2020, refinanced as part of the Debt Consolidation, and $365 million of undrawn lines of credit with expiration dates ranging from September 2019 through August 2020 that can be used to support obligations to fund tenders of VRDBs and pay maturing principal of commercial paper, and a $69 million credit facility to support letters of credit expiring in June 2020.

CommonSpirit maintained two lines of credit with separate banks used to advance refund debt. The credit facilities expire in December 2019 and June 2020. The amounts outstanding under these credit facilities was $249 million and $400 million, respectively, as of June 30, 2019. During 2019, the maximum amount outstanding on these lines was $249 million and $400 million, respectively. These two lines of credit were refinanced as part of the Debt Consolidation.

CommonSpirit also maintained a $35 million single-bank line of credit facility for standby letters of credit. Letters of credit issued under this facility were $27 million as of June 30, 2019, but no amounts have been drawn.

2019 Financing Activity – In July 2018, CHI issued $275 million of Series 2018A taxable bonds subject to mandatory tender in August 2021. Proceeds were used to fund the $275 million Series 2013D taxable bonds principal payment due in August 2018. Additionally, in July 2018, CHI extended the mandatory purchase date of the $250 million Series 2017A taxable bonds from August 2018 to July 2021. As a result, CHI classified the Series 2013D and Series 2017A taxable bonds as long-term debt as of June 30, 2018.

In August 2018, CHI issued $200 million of Series 2018B taxable bonds subject to mandatory tender in August 2019. The proceeds were subsequently used to reimburse the funding of the $200 million Series 2016 taxable bonds, which were subject to mandatory tender in September 2018. These bonds were refinanced by the 2019 taxable bonds.

In June 2019, Dignity Health renewed and extended the letter of credit issued in June 2017 to support VRDBs of $91 million to June 2021. This did not change the terms, provisions or classification of the VRDBs.

In February 2019, Dignity Health renewed its $400 million taxable line of credit scheduled to mature from June 2019 to June 2020. This taxable line of credit was refinanced with the August 2019 taxable bonds.

In July 2019, Dignity Health entered into $1.2 billion of bridge loans with three banks to advance refund certain CHI fixed rate bonds using acquisition financing treatment.

In August 2019, CommonSpirit issued $2.5 billion of tax-exempt fixed rate bonds. Proceeds were used to refinance $1.1 billion of the bridge loans entered into in July 2019, refund $1.4 billion of tax-exempt fixed rate bonds that were placed in escrow and the bonds defeased, refund $322 million of commercial paper, and provide $106 million for general working capital purposes. The bonds were sold at a premium and mature in August 2044 and 2049.

In August 2019, CommonSpirit issued $621 million of tax-exempt put bonds. Proceeds included $569 million of new money and were used to refund $161 million of tax-exempt fixed rate bonds, which were placed in escrow, and the bonds were defeased. The bonds were sold at a premium and mature in August 2049, with mandatory purchase dates in August 2024, 2025 and 2026.

In August 2019, CommonSpirit Health issued $3.3 billion of taxable fixed rate bonds at par, with repayments of $770 million, $915 million, $700 million (insured) and $930 million to be made in October 2024, 2029, 2049 (insured) and 2049, respectively. A portion of the proceeds were used to refund $1.5 billion of CHI tax-exempt fixed rate bonds, refinance $945 million of Dignity Health bank lines of credit, refinance $353 million of Dignity Health direct placement variable rate bank loans, refinance $338 million of Dignity Health taxable

bonds, refinance $137 million of the bridge loans (see below), refund $41 million of Dignity Health tax-exempt fixed rate bonds, refinance $5 million of commercial paper, and pay cost of issuance expenses. Refunded bonds were placed in escrow and were defeased. The bonds were sold at par and mature in October 2049.

In September 2019, CommonSpirit renewed and extended three letters of credit issued by Dignity Health in October 2015 to support VRDBs of $76 million, $60 million, and $60 million, to October 2022. This did not change the terms, provisions or classification of the VRDBs.

***2018 Financing Activity* –** In August 2017, CHI redeemed $35 million of bonds originally acquired in fiscal year 2016 as part of the acquisition of Trinity Health System. The bond redemption was funded from cash and investments, resulting in a gain on redemption of $0.2 million reflected in the accompanying consolidated statements of operations and changes in net assets.

In October 2017, CHI issued $250 million of Series 2017A variable-rate direct purchase taxable bonds subject to mandatory tender in October 2018. Proceeds were used to pay the $250 million principal payment due on Series 2012 fixed-rate taxable bonds.

In December 2017, CHI issued $334 million of Series 2017B fixed-rate direct purchase exempt bonds subject to mandatory tender in December 2018. Proceeds were used to pay the $333 million bank loan that matured in December 2017.

In March 2018, CHI issued $66 million in commercial paper notes. Proceeds were used to pay $35 million in principal payments, and for general purposes and capital expenditures.

16. DERIVATIVE INSTRUMENTS

CommonSpirit's derivative instruments include 31 floating-to-fixed rate interest rate swaps as of June 30, 2019. CommonSpirit uses floating-to-fixed interest rate swaps to manage interest rate risk associated with outstanding variable rate debt. Under these floating-to-fixed rate swaps, CommonSpirit receives a percentage of LIBOR ranging from 57% to 100%, plus a spread ranging from 0.13% to 1.43%, and pays a fixed rate. CommonSpirit's derivative instruments also include five fixed-to-floating interest rate swaps and 16 total return swaps as of June 30, 2019. CommonSpirit uses these fixed-to-floating derivatives to reduce interest expense associated with fixed rate debt and receives a fixed rate and pays a variable rate percentage of SIFMA plus a spread.

The following table shows the outstanding notional amount of derivative instruments measured at fair value, net of credit value adjustments, as reported in the accompanying consolidated balance sheets as of June 30, 2019 and 2018 (in millions):

	Maturity Date of Derivatives	Interest Rate	Notional Amount Outstanding	Fair Value
			2019	
Derivatives not designated as hedges:				
Interest rate swaps	2024 - 2047	3.2% - 4.0%	$ 2,252	$ (454)
Risk participation agreements	2019 - 2025, with extension options	SIFMA plus spread	510	-
Total return swaps	2020 - 2024	SIFMA plus spread	408	-
Total derivative instruments			3,170	(454)
Cash collateral			-	240
Derivative instruments, net			$ 3,170	$ (214)
			2018	
Derivatives not designated as hedges:				
Interest rate swaps	2024 - 2047	3.2% - 4.0%	$ 1,403	$ (207)
Total return swaps	2018-2020	SIFMA plus spread	154	(1)
Total derivative instruments			1,557	(208)
Cash collateral			-	175
Derivative instruments, net			$ 1,557	$ (33)

CHI's cash collateral balances are netted against the fair value of the swaps, the net amount of which is reflected in derivative instruments in the accompanying consolidated balance sheets, with the fair value of Dignity Health's swaps.

CHI held $1.4 billion notional amount of interest rate swaps at June 30, 2019, which have a negative fair value of $276 million. CHI posted $240 million of collateral against the fair value of these swaps.

The CHI interest rate swaps mature between 2024 and 2047. CHI has the right to terminate the swaps prior to maturity for any reason. The termination value would be the fair value or the replacement cost of the swaps, depending on the circumstances. All of the derivative agreements have certain early termination triggers caused by an event of default or a termination event. The events of default include failure to make payment when due, failure to give notice of a termination event, failure to comply with or perform obligations under the agreements, bankruptcy or insolvency, and defaults under other agreements (cross-default provision). The termination events include credit ratings dropping below Baa3/BBB- (Moody's/Standard & Poor's) by either party on the notional amount of $565 million of interest rate swaps and below Baa2/BBB on a notional amount of $625 million of interest rate swaps.

Based upon CHI's swap agreements in place as of June 30, 2019, a reduction in CHI's credit rating to BBB would obligate CHI to post additional cash collateral of $29 million. If CHI's credit rating were to fall below BBB, the swap counterparties would have the option to require CHI to settle the swap liabilities of $35 million as of June 30, 2019, which are recorded at fair value, net of cash collateral. Generally, it is CHI's policy that all counterparties have an AA rating or better. The swap agreements generally require CHI to provide collateral if

CHI's liability, determined on a fair value basis, exceeds a specified threshold that varies based upon the rating on CHI's long-term indebtedness.

CHI has total return swaps in the notional amount of $138 million and a negative fair value of $1 million at June 30, 2019.

Of the $889 million notional amount of interest rate swaps held by Dignity Health at June 30, 2019, $160 million are insured and have a negative fair value of $50 million. In the event the insurer is downgraded below A2/A or A3/A- (Moody's/Standard and Poor's), the counterparties have the right to terminate the swaps if Dignity Health does not provide alternative credit support acceptable to them within 30 days of being notified of the downgrade. If the insurer is downgraded below the thresholds noted above and Dignity Health is downgraded below Baa3/BBB- (Moody's/Standard and Poor's), the counterparties have the right to terminate the swaps.

Dignity Health has $729 million of interest rate swaps that are not insured as of June 30, 2019. While Dignity Health has the right to terminate the swaps prior to maturity for any reason, counterparties have various rights to terminate, including swaps in the outstanding notional amount of $100 million at each five-year anniversary date commencing in March 2023 and swaps in the notional amount of $204 million at each five-year anniversary date commencing in September 2023. Swaps in the notional amounts of $60 million and $68 million have mandatory puts in March 2021 and March 2023, respectively. The termination value would be the fair value or the replacement cost of the swaps, depending on the circumstances. These interest rate swaps have a negative fair value of $78 million at June 30, 2019. The remaining uninsured interest rate swaps in the notional amount of $297 million have a negative fair value of $50 million as of June 30, 2019.

Dignity Health has floating rate derivatives in the notional amount of $780 million as of June 30, 2019. Risk participation agreements in the notional amount of $510 million have a fair value deemed immaterial as of June 30, 2019. Dignity Health has a total return swap in the notional amount of $270 million. The total return swap has a positive fair value of $1 million at June 30, 2019.

All of Dignity Health's derivative agreements have certain early termination triggers caused by an event of default or a termination event. The events of default include failure to make payment when due, failure to give notice of a termination event, failure to comply with or perform obligations under the agreements, bankruptcy or insolvency, and defaults under other agreements (cross-default provision). Other than the insured swaps described above, the termination events include credit ratings dropping below Baa1/BBB+ (Moody's/Standard & Poor's) by either party on the notional amount of $709 million of swaps and below Baa2/BBB on a notional amount of $800 million, and Dignity Health's cash on hand dropping below 85 days.

As part of the August 2019 Debt Consolidation, all swaps and derivative bank counterparties consented to the CommonSpirit Health MTI.

17. INTEREST EXPENSE, NET

The components of interest expense, net, include the following (in millions):

	2019	2018
Interest and fees on debt	$ 414	$ 321
Capitalized interest expense	(23)	(8)
Interest expense, net	$ 391	$ 313

18. RETIREMENT PROGRAMS

CommonSpirit maintains defined benefit pension plans and other postretirement benefit plans that cover most Dignity Health and CHI employees. Benefits for both types of plans are generally based on age, years of service and employee compensation.

Certain of CHI's plans were frozen in previous years, and benefits earned by employees through that time period remain in the retirement plans, where employees continue to receive interest credits and vesting credits, if applicable.

Actuarial valuations are performed for all of the plans. These valuations are dependent on various assumptions. These assumptions include the discount rate and the expected rate of return on plan assets (for pension), which are important elements of expense and liability measurement. Other assumptions involve demographic factors such as retirement age, mortality, turnover and the rate of compensation increases. CommonSpirit evaluates all assumptions in conjunction with the valuation updates and modifies them as appropriate.

Pension costs and other postretirement benefit costs are allocated over the service period of the employees in the plans. The principle underlying this accounting is that employees render service ratably over the period, and therefore, the effects in the accompanying consolidated statements of operations and changes in net assets follow the same pattern. Net actuarial gains and losses are amortized to expense on a plan-by-plan basis when they exceed the accounting corridor. The accounting corridor is a defined range within which amortization of net gains and losses is not required and is equal to 10% of the greater of the plan assets or benefit obligations. Gains or losses outside of the corridor are subject to amortization over the average employee future service period.

Contributions to the defined benefit pension plans are based on actuarially determined amounts sufficient to meet the benefits to be paid to plan participants. Dignity Health management believes the majority of its plans qualify under a church plan exemption, and as such, are not subject to Employee Retirement Income Security Act ("ERISA") funding requirements. CommonSpirit's funding policy requires that, at a minimum, contributions equal the unfunded normal cost plus amortization of any unfunded actuarial accrued liability. Contributions to these funded plans are anticipated at $227 million in 2020, which exceeds the funding policy minimum contributions.

The accumulated benefit obligation exceeds plan assets for each of the defined benefit plans and postretirement benefit plans for the years ended June 30, 2019 and 2018. The following summarizes the benefit obligations and funded status for the defined benefit pension and postretirement benefit plans (in millions):

	2019	2018
Change in benefit obligation:		
Benefit obligation at beginning of period	$ 4,960	$ 5,178
Service cost	146	14
Interest cost	286	164
Plan changes/amendments	-	(13)
Actuarial (gain) loss	1,239	(40)
Acquisitions and other	6,494	-
Administrative expenses paid	(12)	(2)
Settlements	(176)	(217)
Benefits paid	(260)	(124)
Benefit obligation at end of period	$ 12,677	$ 4,960
Accumulated benefit obligation	$ 12,235	$ 4,956
Change in plan assets:		
Fair value of plan assets at beginning of period	$ 4,106	$ 4,067
Actual return on plan assets	532	273
Settlements	(176)	(217)
Employer contributions	126	109
Benefits paid	(260)	(124)
Acquisitions and other	4,861	-
Administrative expenses paid	(12)	(2)
Fair value of plan assets at end of period, net	$ 9,177	$ 4,106
Funded status	$ (3,500)	$ (854)

The following table summarizes the amounts recognized in net assets without donor restrictions as of June 30 (in millions):

	2019	2018
Net actuarial loss	$ 2,240	$ 1,215
Prior service credit	(12)	(13)
Amounts in net assets without donor restrictions	$ 2,228	$ 1,202

The settlement component of net periodic pension cost is recognized in the accompanying statements of operations and changes in net assets within special charges and other costs.

The following table summarizes the weighted-average assumptions used to determine benefit obligations as of June 30:

	2019	2018
To determine benefit obligations:		
Discount rate	2.4% - 3.7%	4.1% - 4.3%
Rate of compensation increase	3.8%	N/A
To determine net periodic benefit cost:		
Discount rate	3.2% - 4.3%	3.7% - 4.2%
Expected return on plan assets	4.8% - 7.5%	5.5% - 7.2%
Rate of compensation increase	3.8%	N/A

The following table summarizes the components of net periodic cost (gain) recognized in the accompanying consolidated statements of operations and changes in net assets (in millions):

	2019	2018
Service cost	$ 146	$ 14
Interest cost	286	164
Expected return on plan assets	(425)	(284)
Settlements	60	55
Net prior service credit amortization	(1)	(2)
Net actuarial loss amortization	47	49
Net periodic benefit cost (gain)	$ 113	$ (4)

The amounts above are recorded in salaries and benefits on the accompanying consolidated statements of operations and changes in net assets, other than settlements which are recorded in special charges and other.

The following represents the fair value of plan assets, net, measured on a recurring basis as of June 30 (in millions). See Note 8 for the definition of Levels 1, 2 and 3 in the fair value hierarchy and investments valued using the NAV practical expedient and discussion regarding fair value measurement.

	2019			
	Quoted Prices in Active Markets for Identical Instruments (Level 1)	**Significant Other Observable Inputs (Level 2)**	**Significant Unobservable Inputs (Level 3)**	**Total**
Assets				
Cash and short-term investments	$ 398	$ 33	$ -	$ 431
U.S. government securities	802	53	-	855
U.S. corporate bonds	-	769	-	769
U.S. equity securities	1,986	10	-	1,996
U.S. term loans	-	-	159	159
Foreign corporate bonds	-	119	-	119
Foreign equity securities	1,128	-	-	1,128
Foreign term loans	-	-	38	38
Other	-	67	-	67
Assets measured at fair value	$ 4,314	$ 1,051	$ 197	5,562
Assets at NAV:				
U.S. corporate bonds				596
U.S. equity securities				159
Foreign corporate bonds				100
Foreign equity securities				651
Private equity				1,066
Hedge funds				813
Real estate				347
Total assets				$ 9,294
Liabilities				
Foreign currency exchange contracts	$ -	$ 39	$ -	$ 39
Payable under securities lending program	-	15	-	15
Total liabilities	$ -	$ 54	$ -	$ 54
Other plan assets (liabilities)				
Due from brokers for unsettled investment trades				229
Due to brokers for unsettled investment trades				(292)
Fair value of plan assets, net				$ 9,177

	2018			
	Quoted Prices in Active Markets for Identical Instruments (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Assets				
Cash and short-term investments	$ 170	$ 54	$ -	$ 224
U.S. government securities	382	41	-	423
U.S. corporate bonds	-	686	-	686
U.S. equity securities	1,059	4	-	1,063
U.S. term loans	-	-	153	153
Foreign corporate bonds	-	117	-	117
Foreign equity securities	682	1	-	683
Foreign term loans	-	-	35	35
Other	2	88	-	90
Assets measured at fair value	$ 2,295	$ 991	$ 188	3,474
Assets at NAV:				
Private equity				406
Real estate				327
				$ 4,207
Liabilities - Foreign currency exchange contracts	$ -	$ 88	$ -	$ 88
Other plan assets (liabilities)				
Due from brokers for unsettled investment trades				49
Due to brokers for unsettled investment trades				(62)
Fair value of plan assets, net				$ 4,106

The following table presents the change in the balance of Level 3 finanical assets in 2019 and 2018 (in millions):

	2019	2018
Balance at beginning of period	$ 188	$ 182
Total realized losses, net	(1)	-
Total unrealized losses, net	(2)	(1)
Purchases	12	7
Balance at end of period	$ 197	$ 188

The following table summarizes the weighted-average asset allocations by asset category for the pension plans:

	2019	2018
Cash and cash equivalents	5%	5%
U.S. government securities	9%	10%
U.S. corporate bonds	15%	16%
U.S. equity securities	23%	25%
U.S. term loans	2%	4%
Foreign corporate bonds	2%	3%
Foreign equity securities	19%	16%
Private equity	11%	10%
Other	14%	11%
Total	100%	100%

The asset allocation policy for the pension plans for 2019 and 2018 is as follows: domestic fixed income, 40%; domestic equity, 25%; international equity, 15%; private equity, 6%; hedge funds, 8%; and real estate, 6%.

CommonSpirit's investment strategy for the assets of the pension plans is designed to achieve returns to meet obligations and grow the assets of the portfolios longer term, consistent with a prudent level of risk. The strategy balances the liquidity needs of the pension plans with the long-term return goals necessary to satisfy future obligations. The target asset allocation is diversified across traditional and non-traditional asset classes. Diversification is also achieved through participation in U.S. and non-U.S. markets, market capitalization, and investment manager style and philosophy. The complementary investment styles and approaches used by both traditional and alternative investment managers are aimed at reducing volatility while capturing the equity premium from the capital markets over the long term. Risk tolerance is established through consideration of plan liabilities, plan funded status, and corporate financial condition. Consistent with CommonSpirit's fiduciary responsibilities, the fixed income allocation generally provides for security of principal to meet near-term expenses and obligations. Periodic reviews of the market values and corresponding asset allocation percentages are performed to determine whether a rebalancing of the portfolio is necessary.

CommonSpirit's pension plan portfolio return assumptions for 2019 and 2018 were based on the long-term weighted-average returns of comparative market indices for the asset classes represented in the portfolio and expectations about future returns.

The following benefit payments, which reflect expected future service, are expected to be paid (in millions):

2020	$ 698
2021	629
2022	655
2023	675
2024	689
2025 and thereafter	3,644
Total	$ 6,990

CommonSpirit maintains defined contribution retirement plans for most employees. Employer contributions to those plans of $273 million and $219 million for 2019 and 2018, respectively, included in salaries and benefits in the accompanying consolidated statements of operations and changes in net assets, are primarily based on a percentage of a participant's contribution.

19. SPECIAL CHARGES AND OTHER COSTS

Special charges include costs related to the following activities:

	2019	2018
Impairment on carrying value of long-lived assets	$ 123	$ 14
Changes in business operations	59	53
Pension settlement costs	60	53
Affiliation-related costs	77	21
Total special charges and other costs	$ 319	$ 141

Charges related to changes in business operations include costs incurred periodically to implement reorganization efforts within specific operations in order to align CommonSpirit's operations in the most strategic and cost-effective manner, consisting primarily of consulting and severance costs. Affiliation costs primarily relate to legal, consulting and labor-related costs.

20. INVESTMENT INCOME, NET

Investment income, net, on assets limited as to use, cash equivalents, notes receivable, the CHI Operating Investment Program, and investments are comprised of the following (in millions):

	2019	2018
Interest and dividend income, net	$ 160	$ 144
Net realized gains on sales of securities	290	287
Net unrealized gains on securities	162	12
Investment income, net	$ 612	$ 443

21. COMMITMENTS, CONTINGENT LIABILITIES, GUARANTEES AND OTHER

The following summary encompasses matters related to litigation, regulatory and compliance matters, and developments thereto.

General – The health care industry is subject to voluminous and complex laws and regulations of federal, state and local governments. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time. These laws and regulations include, but are not necessarily limited to, the rules governing licensure, accreditation, controlled substances, privacy, government program participation, government reimbursement, antitrust, anti-kickback, prohibited referrals by physicians, false claims, and in the case of tax-exempt organizations, the requirements of tax exemption. Management believes CommonSpirit is materially in compliance with all applicable laws and regulations of the Medicare and Medicaid programs. Compliance with such laws and regulations is complex and can be subject to future governmental interpretation as well as significant regulatory action, including fines, penalties and exclusion from the Medicare and Medicaid programs. Certain CommonSpirit entities have been contacted by governmental agencies regarding alleged violations of Medicare practices for certain services. In the opinion of management after consultation with legal counsel, the ultimate outcome of these matters will not have a material adverse effect on CommonSpirit's consolidated financial statements.

In recent years, government activity has increased with respect to investigations and allegations of wrongdoing. In addition, during the course of business, CommonSpirit becomes involved in civil litigation. Management assesses the probable outcome of unresolved litigation and investigations and records contingent liabilities reflecting estimated liability exposure. Following is a discussion of matters of note.

U.S. Department of Justice and OIG Investigations – CommonSpirit and/or its facilities periodically receive notices from governmental agencies, such as the U.S. Department of Justice or the Office of Inspector General ("OIG"), requesting information regarding billing, payment, or other reimbursement matters, or initiating investigations, or indicating the existence of whistleblower litigation. The health care industry in general is experiencing an increase in these activities, as the federal government increases enforcement activities and institutes new programs designed to identify potential irregularities in reimbursement or quality of patient care. Resolution of such matters can result in civil and/or criminal charges, cash payments and/or administrative measures by the entity subject to such investigations. CommonSpirit does not presently have information indicating that pending matters or their resolution will have a material effect on CommonSpirit's financial statements, taken as a whole. Nevertheless, there can be no assurance that the resolution of matters of these types will not affect the financial condition or operations of CommonSpirit, taken as a whole.

Within this category of activities, in October 2014, Dignity Health completed a civil settlement and entered into a Corporate Integrity Agreement ("CIA") with the OIG to resolve an investigation into government reimbursement of hospital inpatient stays. The CIA requires, for a five-year period, enhanced compliance program obligations, education and training, and that Dignity Health retain an independent review organization to review the accuracy of certain claims for hospital services furnished to federal health care program beneficiaries.

Pension Plan Litigation – In April 2013, Dignity Health was served with a class action lawsuit filed in the United States District Court for the Northern District of California by a former employee alleging breaches of fiduciary duty and other claims under ERISA in connection with the Dignity Health Pension Plan ("DHPP"). Among other things, the complaint originally alleged that, because Dignity Health is not a church or an association of churches, the DHPP does not qualify as a "church plan". The complaint also challenged the constitutionality of ERISA's church plan exemption. Dignity Health and the sponsoring religious orders established the DHPP and determined the DHPP was a church plan that should be exempt from ERISA, including ERISA's funding requirements, and received private letter rulings from the Internal Revenue Service that confirmed its church plan status. The plaintiff sought to represent a class comprised of participants and beneficiaries of the DHPP as of April 2013, when the complaint was filed.

In July 2014, the District Court ruled that only a church or an association of churches may establish a church plan, the DHPP did not qualify as a church plan since Dignity Health was not a church when the plan was established, and, therefore, DHPP was not exempt from ERISA. Dignity Health appealed the decision. In July 2016, the Ninth Circuit Court of Appeals issued its opinion, which affirmed the District Court's order and held that a church plan must be established by a church or by an association of churches and must be maintained either by a church or by a church-controlled or church-affiliated organization whose principal purpose or function is to provide benefits to church employees. The Ninth Circuit remanded the case to the District Court for further proceedings.

Dignity Health appealed the decision to the United States Supreme Court, which agreed to hear Dignity Health's case together with those of two other faith-based health systems facing similar challenges to church plan status.

In June 2017, the Supreme Court issued its unanimous opinion reversing the decision of the Ninth Circuit. The Court concluded that the 1980 amendment to Section 3(33)(C) of ERISA was intended by Congress to expand the types of pension plans that could qualify as church plans to include plans maintained by faith-based organizations such as Dignity Health and regardless of who first established the plans. The decision did not determine whether Dignity Health satisfied the requirements to maintain a church plan. In fact, the Court specifically noted that it was not deciding (1) whether any hospital was sufficiently associated with a church for its pension plan to qualify for the church plan exemption, or (2) whether an internal retirement committee could qualify as a "principal purpose" organization entitled to maintain a church plan. The Supreme Court remanded the case to the Ninth Circuit for further action based on its decision.

Based on the Supreme Court's decision, the Ninth Circuit returned the case to the District Court to continue the proceedings with regard to the two outstanding questions and other claims that were not decided by the Supreme Court. The plaintiff amended its original complaint in November 2017, and Dignity Health filed a motion to dismiss the case in December 2017. The motion was heard in March 2018. In September 2018, the District Court issued its ruling denying Dignity Health's motion to dismiss. The decision was primarily based upon the procedural standard that requires the Court to accept the plaintiff's allegations in the amended

complaint as true and does not permit Dignity Health to refute those allegations. As a result, the Court found that the amended complaint was sufficient to withstand dismissal at this stage, but encouraged the parties to further develop the factual record as a basis to consider Dignity Health's objections in the future.

The parties have agreed in principle to resolve the litigation. An unopposed motion for approval of the terms of settlement is currently pending before the court for approval. Management does not believe that the proposed settlement will have a material adverse effect on the financial position or results of operations of the System.

Operating Leases – CommonSpirit leases various equipment and facilities under operating leases. Net rental expense for 2019 and 2018 was $410 million and $329 million, respectively. These amounts are recorded in purchased services and other on the accompanying statements of operations and changes in net assets.

Net future minimum lease payments under non-cancelable operating leases as of June 30 are as follows (in millions):

	2019
2020	$ 331
2021	278
2022	239
2023	211
2024	189
Thereafter	647
Total	$ 1,895

Capital and Purchase Commitments – CommonSpirit has legally committed to fund $1 billion of capital improvements related to certain acquisitions and affiliations, has undertaken various construction and expansion projects that include certain capital commitments, and has entered into various agreements that require certain minimum purchases of goods and services, including management services agreements or information and clinical technology, at levels consistent with normal business requirements. Outstanding capital and purchase commitments were approximately $848 million and $169 million at June 30, 2019, respectively.

22. FUNCTIONAL EXPENSES

CommonSpirit provides healthcare services, including inpatient, outpatient, ambulatory, long-term care and community-based services to individuals within the various geographic areas supported by its facilities. Expenses for these program services represent costs that are controllable by operational leadership. Support services include administration, financial services and purchasing, financial planning and budgeting, information technology, risk management, public relations, human resources, cash, debt and investment management, legal, mission services, and other functions that are supported centrally for all of CommonSpirit and are driven by CommonSpirit leadership. Following is a summary of the program and support services provided for the year ended June 30, 2019:

	Program Services - Healthcare	**Support Services - Management and Administrative**	**Support Services - Fundraising**	**Total Expenses**
Salaries and benefits	$ 9,654	$ 490	$ 17	$ 10,161
Supplies	3,317	20	-	3,337
Purchased services and other	5,323	898	52	6,273
Depreciation and amortization	846	241	-	1,087
Interest expense	375	16	-	391
Total recurring expenses	$ 19,515	$ 1,665	$ 69	$ 21,249

Management and administrative expenses as a percentage of total operating expense was approximately 7.7% in 2018.

23. UNSPONSORED COMMUNITY BENEFIT EXPENSE (UNAUDITED PRO FORMA)

Unsponsored community benefits are programs or activities that provide treatment and/or promote health and healing as a response to identified community needs. These benefits (a) generate a low or negative margin, (b) respond to the needs of special populations, such as persons living in poverty and other disenfranchised persons, (c) supply services or programs that would likely be discontinued, or would need to be provided by another nonprofit or government provider, if the decision was made on a purely financial basis, (d) respond to public health needs, and/or (e) involve education or research that improves overall community health. The following information is presented on a pro forma basis, assuming the operations of Dignity Health and CHI were combined as of July 1, 2018.

Benefits for the Poor include services provided to persons who are economically poor or are medically indigent and cannot afford to pay for health care services because they have inadequate resources and/or are uninsured or underinsured.

Benefits for the Broader Community refer to programs in the general communities that CommonSpirit serves, beyond and including those for a target population. Most services for the broader community are aimed at improving the health and welfare of the overall community. Such services include the interest rate differential on below-market-rate loans CommonSpirit provides to nonprofit organizations that promote the total health of their local communities, including the development of affordable housing for low-income persons and families, increasing opportunities for jobs and job training, and expanding access to health care for uninsured and underinsured persons.

Traditional Charity Care is free or discounted health services provided to persons who cannot afford to pay and who meet CommonSpirit's criteria for financial assistance.

Net Community Benefit, excluding the unpaid cost of Medicare, is the total cost incurred after deducting direct offsetting revenue from government programs, patients, and other sources of payment or reimbursement for services provided to program patients. The comparable amount of net community benefit was $2 billion for 2018, and Net Community Benefit, including the unpaid cost of Medicare, was $4 billion for 2018.

Following is a summary of CommonSpirit's community benefits for 2019, in terms of services to the poor and benefits for the broader community, which has been prepared in accordance with Internal Revenue Service Form 990, Schedule H and the CHA publication, *A Guide for Planning and Reporting Community Benefit* (dollars in millions):

	Unaudited Pro Forma			
	Total Benefit Expense	**Direct Offsetting Revenue**	**Net Community Benefit**	**% of Total Expenses**
Benefits for the poor:				
Traditional charity care	$ 317	$ (28)	$ 289	1.4%
Unpaid costs of Medicaid / Medi-Cal	4,550	(3,109)	1,441	6.8%
Other means-tested programs	23	(10)	13	0.1%
Community services:				
Community health services	58	(27)	31	0.1%
Subsidized health services	33	(1)	32	0.2%
Donations and other	52	(2)	50	0.2%
Total community services for the poor	143	(30)	113	0.5%
Total benefits for the poor	5,033	(3,177)	1,856	8.8%
Benefits for the broader community:				
Community services:				
Community health services	103	(4)	99	0.5%
Health professions education	128	(15)	113	0.5%
Subsidized health services	23	(6)	17	0.1%
Research	131	(36)	95	0.4%
Donations and other	7	(1)	6	0.0%
Total benefits for the broader community	392	(62)	330	1.5%
Total Community Benefits	$ 5,425	$ (3,239)	$ 2,186	10.3%
Unpaid costs of Medicare	5,957	(3,708)	2,249	10.6%
Total Community Benefits including unpaid costs of Medicare	$ 11,382	$ (6,947)	$ 4,435	20.9%

* * *

Annual Report

As of and for the fiscal year ended June 30, 2018

Information Concerning Catholic Health Initiatives

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APPENDIX A : CATHOLIC HEALTH INITIATIVES CONSOLIDATED FINANCIAL STATEMENTS AND SUPPLEMENTAL INFORMATION FOR THE YEARS ENDED JUNE 30, 2018 AND 2017

Certain of the discussions included in this Annual Report may include forward-looking statements. Such statements are generally identifiable by the terminology used such as "believes," "anticipates," "intends," "scheduled," "plans," "expects," "estimates," "budget" or other similar words. Such forward-looking statements are primarily included in PARTS II, III, IV and VII. These statements reflect the current views of management with respect to future events based on certain assumptions, and are subject to risks and uncertainties. Catholic Health Initiatives, a Colorado non-profit corporation (the "Corporation"), undertakes no obligation to publicly update or review any forward-looking statement as a result of new information or future events.

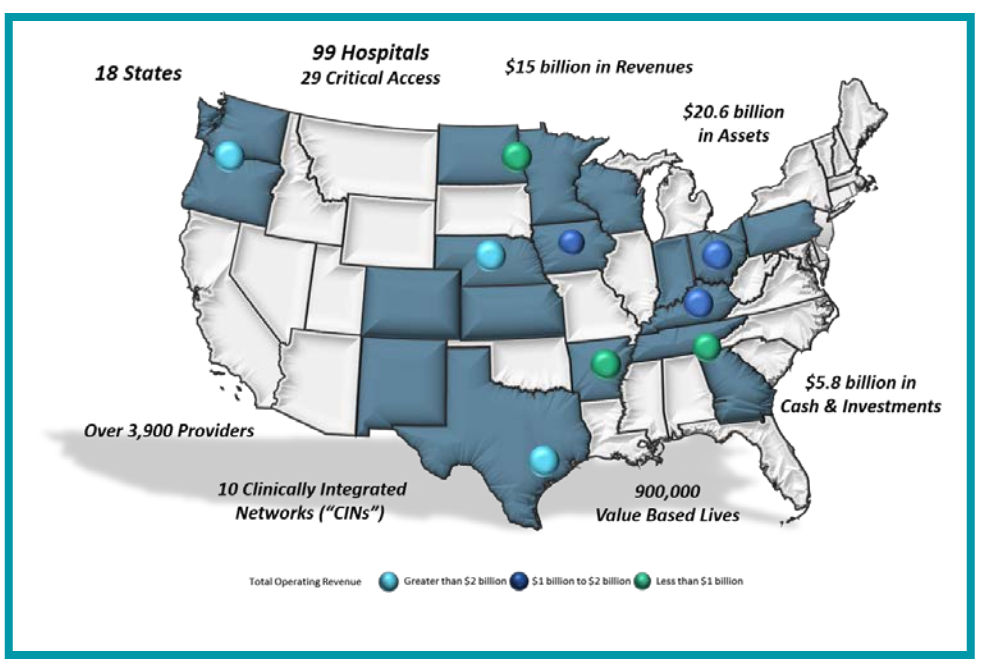
References to "CHI" in this Annual Report are to the Corporation and all of the affiliates and subsidiaries ("Participants") consolidated with it pursuant to generally accepted accounting principles ("GAAP"). References to the Corporation are references only to the parent corporation, and should not be read to include any of the Participants.

Unless otherwise noted, all financial information in this Annual Report, for both fiscal year 2017 and 2018, refers to continuing operations only.

PART I: OVERVIEW

Catholic Health Initiatives ("CHI") is a group of non-profit and for profit organizations that comprise one of the nation's largest Catholic health care systems, serving more than four million people each year through operations and facilities that span the continuum of care, including acute care hospitals; physician practices; long-term care facilities; assisted-living and residential-living facilities; community-based health services; home care; research and development; medical and nursing education; reference laboratory services; virtual health services; managed care programs; and clinically integrated networks. Today, CHI has operations in 18 states, with a service area that covers approximately 54 million people, or approximately 17% of the U.S. population.

CHI is currently comprised of ten regions that are operated as integrated health systems including several joint operating agreements ("JOAs"), joint operating companies ("JOCs") or joint ventures. The geographic diversity and total operating revenues by region for the fiscal year ended June 30, 2018 are depicted in the accompanying map.



PART II: FISCAL YEAR 2018 HIGHLIGHTS & SUMMARY

Fiscal year 2018 performance continued to see positive trends on a consolidated basis and within most of the regions across CHI. CHI experienced significant growth in revenue per adjusted admissions as a result of several revenue cycle improvement initiatives, as well as overall reductions in total labor expense and restructuring, impairment and other losses. After adjusting for transactional gains and other items (as further outlined on pages 28 and 29), operating EBIDA and operating losses improved $477.6 million and $442.9 million, respectively for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30, 2017.

Although volume declines were experienced in most regions and are reflective of industry trends, the revenue cycle improvements and cost reductions more than mitigated this impact. The Texas region continued to improve throughout the fiscal year after producing lower results in the first quarter of the fiscal year ended June 30, 2018 due to the impact of Hurricane Harvey. The Nebraska region's performance rebounded substantially with an Operating EBIDA before restructuring, impairment and other losses of $238.3 million and $106.7 million at June 30, 2018 and 2017, respectively. The Kentucky region's continuing operations sustained its strong improvement trend, reporting an operating EBIDA before restructuring, impairment and other losses of $89.1 million for the fiscal year ended June 30, 2018, compared to $68.8 million for the fiscal year ended June 30, 2017. For a more detailed discussion on CHI's regions, see *Parts III, IV, V and VII.*

Total Corporate services and other business lines also improved $107.0 million for fiscal year ended 2018, compared to fiscal year ended June 30, 2017, due primarily to decreased expenses in information technology, improvements in other support services functional costs and reduced claims expense in the self-insured welfare benefits program.

Total restructuring, impairment and other losses declined $221.9 million for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30, 2017.

Non-operating income for the fiscal year ended June 30, 2018 declined $205.5 million compared to the fiscal year ended June 30, 2017, due primarily to lower investment income and changes in the market value of interest rate swaps below prior year levels.

($ in millions)	Key Operating Indicators for Continuing Operations Twelve months ended June 30,		
Unaudited	**2018**	**2017**	**Increase**
Operating EBIDA	$ 892.2	$ 520.7	$ 371.5
Operating EBIDA margin	*6.0%*	*3.5%*	
Loss from operations	$ (276.7)	$ (593.4)	$ 316.7
Operating loss margin	*(1.8%)*	*(3.9%)*	
Net Income[1]	$ 222.1	$ 110.9	$ 111.2
Net income margin	*1.4%*	*0.7%*	

[1] Excess (deficit) of revenues over expenses.

In June 2018, the Corporation entered into an asset purchase agreement for the sale of its Medicare Advantage health insurance operations in the State of Washington to be effective in January 2019. In addition, the Corporation entered into a non-binding letter of intent for the sale of the QualChoice commercial operations in the State of Arkansas. Those negotiations related to the QualChoice commercial operations are ongoing with the expectation that a purchase agreement will be executed during fiscal year 2019. While seeking a buyer for its health plan operations, the Corporation has continued to actively manage QualChoice, and has focused on improving operating results of the assets held for sale, moving from an operating EBIDA loss before restructuring, impairment, and other

losses of $(85.4) million in fiscal year 2016 to a positive operating EBIDA before restructuring, impairment and other losses of $8.6 million in fiscal year 2018 - a $94 million improvement over the two fiscal year periods.

PART III: COMPETITIVE STRENGTHS

CHI's size and geographic diversity enable greater economies of scale and efficiencies, as well as provide a level of insulation from unfavorable performance in specific regions. CHI continues to develop a greater market presence in certain legacy regions and to further expand into newer regions as described below in *Part V: Strategic Affiliations & Acquisitions.* CHI's operations in the Colorado, Pacific Northwest, Nebraska, and Texas regions each generated approximately $2 billion or more in total revenues in fiscal year 2018. CHI's key strengths include:

- Strong geographic diversification, with a mix of facilities located in both rural and urban settings, helping to mitigate the effect of changes in reimbursement
- Diversification of operating revenue, with no single region representing more than 18.4% of total operating revenue in fiscal year 2018
- Experienced corporate and clinical management team

Various improvement initiatives over the past several years have been successful in driving changes to operations. However, changes in the health care industry have resulted in additional challenges that have led to decreased volumes and reimbursement shifts between inpatient and outpatient/ambulatory care and payer mix.

CHI REGIONS

CHI's operations are located primarily within ten regions: Colorado, Pacific Northwest, Nebraska, Kentucky, Texas, Iowa, Ohio, Arkansas, Tennessee and North Dakota/Minnesota. A brief description of these regions is below. These descriptions provide a broad overview of each region. Additional detail regarding certain financial and operating information for five of CHI's largest regions, Colorado, Pacific Northwest, Nebraska, Texas and Kentucky is included later in this Annual Report.

Colorado - CHI's Colorado region includes ten acute care hospitals located in Colorado and two in western Kansas. All of these hospitals are operated by Centura Health, the joint operating company created in 1996 by CHI and Adventist Health System (Adventist Health System is based in Altamonte Springs, Florida).

Pacific Northwest - CHI's Pacific Northwest region includes CHI Franciscan Health, which operates seven acute care hospitals in Washington, two in Oregon, as well as Franciscan Medical Group, a regional network of primary-care and specialty-care clinics, physicians and other professional providers. CHI Franciscan Rehabilitation Hospital opened June 2018 and is operated under a joint venture.

Nebraska - CHI's Nebraska region consists of 14 acute care hospitals, two stand-alone behavioral health facilities, and more than 150 clinics throughout Nebraska and southwest Iowa. Creighton University Medical Center - Bergan Mercy is the primary teaching partner of Creighton University's health sciences schools.

Kentucky - Prior to 2012, CHI's Kentucky region consisted primarily of the Saint Joseph Health System, which is based in Lexington, Kentucky and operated eight acute care hospitals throughout Kentucky. In 2012, CHI created KentuckyOne Health ("KentuckyOne"), which integrated certain Louisville operations with CHI's existing Kentucky hospitals. As described below under *Part V: Strategic Affiliations & Acquisitions – Pending and Completed Divestitures*, CHI has reconfigured the Kentucky Region, including the separation of University of Louisville Medical Center from KentuckyOne and the approved divestiture of most or substantially all of the other Louisville-area facilities in the Kentucky region. As of July 1, 2017, the continuing operations of the Kentucky region were segregated from and are operated independently of the discontinued operations (primarily located in central

and eastern Kentucky, with most of the original eight acute care hospitals, as well as physician practices).

Texas - CHI's Texas region serves over 7.7 million people in a broad region of south Texas that stretches across three markets. The largest part of this region is the Houston Market, where the region operates seven acute care facilities. Serving as the referral center for Houston and the region is the Baylor St. Luke's Medical Center. In 2014, CHI St. Luke's ("SLH") entered into a joint venture with Baylor College of Medicine ("BCM") to develop Baylor St. Luke's as a leading academic medical center in the current heart of the Texas Medical Center, as well as to open a new, acute-care, open-staff hospital on BCM's McNair Campus, also in the Texas Medical Center. As part of this joint venture, BCM and SLH became co-members of CHI St. Luke's Medical Center ("SLMC"), with membership percentages of 35% and 65%, respectively, to oversee the operations of Baylor St. Luke's Medical Center at its current location and the expansion of McNair campus, where it will begin to move patient care operations in January 2019. BCM and SLH have also formed a joint venture to create a health care network, including a growing number of physician practices, in the Houston region.

In addition to the Houston hospitals and facilities, the Texas region also includes CHI St. Joseph Health System ("SJHS") and CHI St. Luke's Health Memorial of East Texas ("SLHMET"). SJHS operates five acute care hospitals, a long-term care facility and provides other services, all in the Brazos Valley region of Texas. SJHS joined CHI in 2014 in connection with the Corporation's acquisition of Sylvania Franciscan Health ("SFH"). St. Joseph HealthSouth Rehabilitation Hospital opened August 2016 and is operated under a joint venture with HealthSouth. During 2018, SJHS developed an affiliation agreement in primary care with the Texas A&M College of Medicine, which is being rolled out in the first two quarters of fiscal year 2019. SLHMET also joined CHI in 2014 and operates three acute care hospitals, one specialty hospital and various clinics in the East Texas region.

In 2016, SLH became the sole corporate member of Brazosport Regional Health System ("BRHS"), which is also part of the Houston region, a nonprofit health care organization that includes a 158-licensed bed hospital that operates the only Level III trauma center in Brazoria County, Lake Jackson, Texas.

Iowa - Most of CHI's Iowa operations are managed by Mercy Health Network ("MHN"), which is a joint operating company that was created in 1998 pursuant to a joint operating agreement between CHI and Trinity Health, based in Livonia, Michigan. See *Part V: Pending and Completed Affiliations/Acquisitions* for additional detail regarding MHN. Operations in this region include seven acute care hospitals located in central and eastern Iowa.

Ohio – At June 30, 2018, CHI's Ohio region includes Good Samaritan Hospital, an acute care hospital located in Cincinnati, which is managed by TriHealth, the joint operating company established in 1995 pursuant to a joint operating agreement and Bethesda Hospital, Inc.

CHI also has an interest in Premier Health Partners ("Premier"), which operates several hospitals as well as certain ambulatory/ancillary service centers, joint ventures and other services in the greater Dayton area. See *Part V, Pending and Completed Divestitures and/or Restructurings* for a detailed description of the relationship with Premier.

CHI's Ohio region also includes SFH which operates long term care facilities in Ohio and Kentucky and a critical access hospital in Dennison, Ohio, as well as Trinity Health System ("THS"), which operates two acute care hospitals and provides other services in Steubenville, Ohio.

Arkansas - CHI's Arkansas region includes four acute care hospitals as well as primary care facilities, specialty physician clinics and convenient care clinics.

Tennessee - CHI's Tennessee region includes three acute care hospitals, as well as primary care facilities, specialty clinics, an imaging center and a home health agency.

North Dakota/Minnesota - CHI's North Dakota/Minnesota region includes 14 acute care hospitals in Minnesota and North Dakota, of which 13 are critical access hospitals. The region also operates primary care facilities, specialty clinics and long-term care facilities.

PART IV: STRATEGIC & OPERATIONAL INITIATIVES

A. Strategic Intent

In 2011, the Board of Stewardship Trustees ("the Board") set a revenue diversification goal based on its assessment of the potential impact of health care reform. The Board's vision generated a focus on reducing cost, expanding access to health services and increasing revenue to derive 65% of patient revenues from ambulatory, physician, virtual, post-acute and other non-inpatient revenue sources, using alternate financing models to augment future investments. As of June 30, 2018, CHI had achieved 55.6% of patient revenues from areas other than acute care.

One example of revenue diversification is CHI Health at Home. In 2011, CHI acquired a home health specialty services company including home health, medical transportation services, home medical equipment and home infusion in Indiana, Kentucky and Ohio with approximately 2,300 associates, $124 million in annual managed revenues and 571,000 annual patient encounters. At June 30, 2018, CHI Health at Home operates in eight states, has over 3,300 associates, $285 million in annual managed revenue, with a total of nearly 1.5 million patient encounters. CHI Health at Home provides five distinct but coordinated home-based health services including home care, hospice, home infusion therapy, home medical equipment and medical transportation across CHI and to ten outside partners. CHI Health at Home is actively exploring opportunities to expand into other existing CHI markets and with new partnerships.

CHI adopted a multi-faceted approach to achieve success in both the existing fee-for-service and new payment-for-value environments. To sustain its ministry into the future, four strategic objectives were introduced in the CHI Strategic Plan 2016-2020 and are depicted below.

With a shared vision and strategic objectives setting the course, CHI regions and functional areas consisting of supply chain, revenue cycle, information technology, human resources, treasury and finance, marketing and communication, strategy and other shared services established strategic imperatives to address the realities, opportunities and needs within their communities, with a goal of providing greater clarity of purpose and accountability. CHI is measuring, monitoring and advancing these efforts through the use of the *Living Our Mission Measures* and other key metrics described in *Part III: B. Clarify Purpose and Accountability* below.

B. Clarify Purpose and Accountability

Living Our Mission Measures are nine CHI-wide performance goals that are most vital to our mission: from safety and quality to patient experience and the transition to value-based health care. The Board established more granular goals in each of the functional areas. Region-specific goals align to these CHI-wide goals.

- Commitments to advance equity of care for people in the communities CHI serves
- Expansion of ambulatory care sites to address consumer needs and expectations

CHI also established four strategic measures intended to complement the *Living Our Mission Measures* and to move beyond care delivery to impact the determinants of health. These measures assess:

- Collaboration with community leaders to define and implement initiatives to address health priorities
- Growing the number of consumers CHI serves

Each region and functional area creates its own tactical, measurable plan that integrates these CHI-wide strategies into day-to-day operations.

Living Our Mission Measures

Service to the Poor & Vulnerable

Employee Engagement

Physician Satisfaction

Quality

Patient Experience

Safety

Growth

Transformation

Operating EBIDA

C. Transformative Change Sharpens Focus

CHI has two important parallel initiatives underway: To become a "higher performing" organization and to create a new ministry with Dignity Health ("Dignity"). CHI is focused on meeting its *Living our Mission Measures* and balancing that work with the proposed Dignity alignment, as both initiatives are equally important to the organization. The proposed ministry alignment with Dignity would allow both organizations to have a greater advocacy voice and resources for those in need, as well as for those who are poor and vulnerable and continuing the service of care for the millions of people who depend on both organizations. The integration efforts of the two organizations will focus on incorporating the strengths of both cultures to ensure the new system embodies the best of CHI and Dignity.

CHI remains focused on the work ahead to meet its commitments to the *Living our Mission Measures*. CHI is committed to further advancing the performance improvement achievements of the past several years in the functional areas/workstreams of labor management, revenue cycle, supply chain, the medical group enterprise, non-labor overhead, organic growth and information technology. The philosophy underlying this work was to create operational efficiency, economies of scale, standardization of

systems and processes, cost reductions and savings, growth and revenue enhancement and consolidation and centralization of back-office and core services. By June 30, 2017, CHI met its goal of performance improvement initiatives that increased revenues and/or decreased expenses by approximately $800 million annually. This work continues as CHI's journey to becoming a higher performing organization progresses.

The change in processes provides operational accountability while aligning governance and operating models to ensure high performance. There are four dimensions of the *Living Our Mission Measures* operating model: philosophy outlines expectations for performance; performance metrics measure success; playbooks provide a management support tool; and performance reviews track progress. These four dimensions capture how *Living our Mission Measures* are at the core of CHI operations.

D. Regional Positioning and Performance

During fiscal year 2018, approximately 70.4% of CHI's total operating revenues and approximately 86% of operating EBIDA before restructuring, impairment and other losses were derived from the following five markets:

Colorado – Under Centura Health, the western Kansas and Colorado region continues to be one of CHI's strongest. Its statewide network has grown substantially through ownership, management and affiliation, and capitalizing on the rapid population growth across the state of Colorado. Ambulatory service centers have opened in the northern corridor of the Denver metropolitan area and in the Colorado Springs metropolitan area. The Colorado region has extensive brand and ambulatory presence across metropolitan Denver, Colorado Springs, and other Colorado communities as well as western Kansas. The anticipated 2019 completion of the St. Francis Medical Center in Colorado Springs is expected to address favorable market conditions and population growth in that market. The Colorado region is working to optimize its market relationships and payer partnerships. To do so, Centura is advancing Colorado Health Neighborhoods ("CHN"), its statewide Clinically Integrated Network ("CIN"), which currently has the largest pool of specialists and the most facilities of any CIN in Colorado and western Kansas.

Pacific Northwest ("PNW") - The PNW region continues to be a strong performer for CHI. Areas of strategic focus in the PNW region include extending geographic reach and access through growth of partnerships and ambulatory facilities as well as expanding the Rainier Health Network, the region's CIN. In March 2017, CHI Franciscan Health entered into a clinical partnership and strategic affiliation with Virginia Mason Medical Center ("Virginia Mason") with a goal of serving new

patients through combined clinical institutes in key service lines and enabling the integration of Virginia Mason providers into the Rainier Health Network. In addition, CHI and regional management are pursuing partnership opportunities to expand ambulatory presence across the region.

Construction is underway to build a new, state-of-the-art hospital at Harrison Medical Center in Silverdale, Washington. The multi-phase, $540 million expansion and consolidation of multiple campuses will feature leading-edge medical technology, a new acute care center, and an efficient design. It will also include a medical office building for primary and specialty care physicians. The expected completion date is the first quarter of calendar 2020. Also included in this $540 million, CHI Franciscan is making additional investments in Bremerton, with the anticipated opening of a 32,000 square foot outpatient clinic with primary care and urgent care services in May 2020. The clinic will be part of Harrison Medical Center's new Family Medicine Residency program, which will train highly qualified family medicine physicians. Residents for the new program were selected in August and are expected to begin working out of the clinic in 2019.

Franciscan Health System ("FHS") partnered with Kindred and opened the first rehabilitation hospital in The Puget Sound. The hospital is successfully providing specialized services to the community since its opening in May 2018.

The Franciscan Medical Group ("FMG") added 91 providers during the prior fiscal year, totaling 872 providers, which resulted in a 12.5% increase in physician visits and a 22.2% increase in outpatient surgeries for the fiscal year ended June 30, 2018. The operating loss in the FMG, however, increased compared to the prior fiscal year. Management is addressing this through operational initiatives, including increased provider and staff productivity, as well as through an evaluation of provider compensation arrangements.

Nebraska - The Nebraska region, known as CHI Health, rebounded during fiscal year 2018 with strong financial performance. Operating EBIDA margin before restructuring, impairment and other losses improved from 5.3% at June 30, 2017 to 11.4% at June 30, 2018. CHI Health retooled its approach to performance management and has focused on building core leader strength and accountabilities to achieve results. The bar was raised on performance at all levels of operations including engagement, revenue growth, expense reductions and focused strategy deployment. As a result, net patient services revenues grew 2.7%, labor hours per adjusted admission decreased by 4.9%, supply costs per adjusted admission decreased by 3.6% and total expenses decreased 3.7%, each as compared to the prior fiscal year.

CHI Health's medical group operation losses were reduced by 20.0%, when compared to the prior fiscal year which was the result of planned changes to the physician complement to better align with CHI Health's strategic imperatives. As a result, there has been an increased accountability for results, system alignment and focused cost reduction strategies.

CHI Health, one of the largest integrated health systems in the state of Nebraska and southwest Iowa, continues to pursue success under value-based care initiatives. This includes lower cost options for patients, select direct to employer programs, and introduction of direct primary care sites. As a Medicare Shared Savings track 3 participant, CHI Health achieved shared savings in excess of $4 million during fiscal year 2018. CHI Health is implementing a statewide electronic medical record system, Epic, that will be completed in early fiscal year 2020, to further streamline access and interoperability for its patients.

Texas – The Texas region improved operationally and financially during fiscal year 2018. Operating EBIDA margin before restructuring, impairment and other losses improved from $64.3 million at June 30, 2017 to $84.3 million at June 30, 2018, despite the adverse impact of Hurricane Harvey in August 2017. It is estimated that the impact of the hurricane, net of business interruption insurance proceeds, adversely affected the Texas region overall financial performance by $11 million.

Fiscal year 2018 was also a year of leadership transition for the region. In March 2018, T. Douglas Lawson, PhD, was named President and Chief Executive Officer. Dr. Lawson was previously the President of Baylor Scott & White Medical Center, Dallas, Texas. In July 2018, Mark J. McGinnis, was named Senior Vice President and Chief Financial Officer. Mr. McGinnis, a seven-year CHI veteran, was previously CHI's System Vice President –

Operational Finance and Integration and CFO overseeing the Arkansas and Tennessee regions. In addition, new presidents were recently named at CHI St. Joseph Health System, Bryan, and at CHI St. Luke's - The Woodlands Hospital.

CHI continues to focus on strengthening its partnership with the BCM. The flagship Texas facility, CHI Baylor St. Luke's Medical Center ("BSLMC"), located in the Texas Medical Center, has recruited key physicians in its transplant, lung surgery and neurosurgery programs. The regional leadership, BSLMC and the Baylor College of Medicine continues to move forward with a plan to expand and/or relocate certain operations in the Texas Medical Center to the McNair campus while enhancing existing facilities and equipment at the current campus.

On December 1, 2017, the Centers for Medicare and Medicaid Services ("CMS") conducted an onsite re-approval survey at BSLMC. On January 19, 2018, CMS determined the results of the survey findings demonstrated the Adult Only Heart Transplant Program ("Program") was out of compliance based on data provided by the Scientific Registry of Transplant Recipients, 2014 to 2015. Subsequently, BSLMC voluntarily suspended its Program for a 14 day-period in June 2018 while it performed an in-depth review of three unsuccessful transplants that had occurred earlier in fiscal year 2018. During the temporary pause, BSLMC completed medical reviews of the recent mortalities, reorganized the transplant surgery team, and instituted improvements designed to strengthen the Program. A special transplant committee, authorized by the BSLMC Board of Directors ("BSLMC Board"), is overseeing reviews and improvements and will continue into next year. In August, the Program was notified that CMS would end reimbursement for Medicare patients effective August 17, 2018. BSLMC has appealed this decision, remains active today and continues to ensure critically ill patients receive the care they need.

Fewer than half of the patients on Baylor St. Luke's heart transplant list typically are covered by Medicare, and the hospital has offered assistance in the transfer of affected Medicare inpatient cases to other transplant programs. Many of these patients have elected to remain with their care team at BSLMC. BSLMC continues as a program in good standing with the United Network for Organ Sharing ("UNOS"), the accrediting body for transplant programs in the United States. To date, the financial impact has been minimal as the Program has historically contributed approximately 2% of net patient services revenues toward the consolidated BSLMC revenue base.

Kentucky –The Kentucky region continued its strong improvement trend for the fiscal year ended June 30, 2018 with an operating EBIDA before restructuring, impairment and other losses of 8.4%. As further described in *Part V: Strategic Affiliations & Acquisitions - Pending and Completed Divestitures,* the transition of certain operations in the Kentucky region continued during fiscal year 2018. The Corporation transitioned the University of Louisville Hospital operations, management and control back to University of Louisville, effective July 1, 2017. Additionally, the Board approved the divestiture of most or substantially all of the other Louisville-area acute facilities in the Kentucky region. During this strategic repositioning period, CHI's Louisville facilities are operated separately from the remainder of the Kentucky region. Effective September 1, 2017, the Corporation assumed complete ownership of KentuckyOne by purchasing the non-controlling interest of the other partner for $150 million. In December 2017, the Corporation entered into a non-binding letter of intent to negotiate a definitive agreement for the sale of most or substantially all of the KentuckyOne Louisville-area acute care operations. Effective July 1, 2018, Saint Joseph Martin was sold to the Appalachian Regional Healthcare. Effective June 28, 2018, the sale of the Southern Rehab Hospital to Vibra Healthcare was finalized.

During the transition of KentuckyOne as discussed above and further described in *Part V: Strategic Affiliations & Acquisitions - Pending and Completed Divestitures,* the retained operations of KentuckyOne will focus on providing high quality and cost-effective care across central and eastern Kentucky, with the acute care hospitals and physician practices to position as a leader in the Commonwealth for the long-term. KentuckyOne will design, balance and grow market-based, local delivery systems by considering multiple care distribution strategies that promote growth by:

- Partnering with leading regional providers along the continuum of care with complementary, clinical and operational capabilities;

- Alignment of providers around clearly defined shared strategic priorities, performance requirements and expectations;
- Further development of ambulatory access through primary/specialty care with strategically located sites of care;
- Expanding regional capabilities to serve the needs of providers and patients in southern Kentucky;
- Enhancing and deploying home health capabilities and service offerings;
- Utilizing telemedicine to enhance access for existing patients and to capture new customers;
- Maintaining high functioning information systems that support effective clinical processes, integrate patient management, and inform performance improvement.

KentuckyOne will continue to offer healthcare services in Kentucky by enhancing access across the care continuum to provide an optimal customer experience and the best possible clinical outcome for the patient. Through partnerships with other providers, innovative care delivery and access models, and continuous performance improvement efforts, KentuckyOne strives to deliver superior value to patients, employers, and payers in the Kentucky region.

E. Transformative Change Drives Organizational Adaptation

Health Plans

CHI created QualChoice Health, Inc. ("QualChoice"), a wholly-owned subsidiary, to support the health plan aspect of CHI's multi-faceted approach to value-based care delivery and corresponding new reimbursement models. QualChoice oversees CHI's portfolio of commercial and Medicare Advantage health insurance plans, care networks and related products and services in markets across CHI's service areas. Through QualChoice, CHI acquired health plans, including its purchase of Soundpath Health, a Medicare Advantage plan in Federal Way, Washington, and its purchase of QualChoice Holdings, Inc. ("QualChoice Holdings"), a commercial health plan based in Little Rock, Arkansas. QualChoice extended its reach through strategic geographic expansion, including a portfolio of third-party administrative services and Medicare Advantage plans in new regions, including Iowa, Kentucky, Nebraska, Ohio and Tennessee.

As part of CHI's performance improvement efforts and strategic realignment, in May 2016, the Board approved a plan to sell or otherwise dispose of QualChoice. CHI's strategy to be an industry leader in population health and valued-based payments has not changed with its redirection relating to health plans. Rather than moving forward with developing health insurance products in a wholly-owned and nationally driven entity, which required a large capital and operational investment, CHI intends to rely on capabilities developed in its regions, CINs and through partnerships and will continue to focus on alignment of its CINs/physicians in existing regions as further described below in *Clinically Integrated Networks/Accountable Care Organizations.*

While CHI has been seeking buyers for its health plan operations, it also has focused on improving operating results of the discontinued operations, moving from an operating EBIDA loss before restructuring, impairment, and other losses of $(85. 4) million in fiscal year 2016 to a positive operating EBIDA before restructuring, impairment and other losses of $8.6 million in fiscal year 2018 - a $94 million improvement over the two fiscal year periods.

In June 2018, the Corporation entered into an asset purchase agreement for the sale of its Medicare Advantage health insurance operations in the State of Washington to be effective in January 2019. In addition, the Corporation entered into a non-binding letter of intent to sell the QualChoice commercial operations in the State of Arkansas. The negotiations related to the QualChoice commercial operations are ongoing with the expectation that a purchase agreement will be executed during fiscal year 2019.

The following summarizes the financial results of QualChoice reported as discontinued operations in the CHI consolidated statements of changes in net assets:

($ in millions)	Twelve Months Ended June 30, 2018	2017	2016
		Unaudited	
QualChoice			
Operating revenues	$562.3	$578.0	$520.4
Operating EBIDA before restructuring	$8.6	$(38.6)	$(85.4)

The CHI consolidated balance sheets include the discontinued operations of QualChoice. At June 30, 2018, total assets held for sale were $167.6 million and total liabilities held for sale were $159.3 million.

Clinically Integrated Networks/Accountable Care Organizations

CHI continues to advance in value-based care and population health management. Driven by further changes in healthcare policy and marketplace payment, CHI's multi-faceted action plan includes:

- Strengthening the scope and depth of its all-payer CINs and Accountable Care Organizations ("ACOs") in each of CHI's regions;
- Aligning CHI payer and physician compensation agreements with value-based outcomes;
- Divesting its wholly-owned national health plan and refocusing on regional joint ventures with payers;
- Intensifying Direct-To-Employer sales for employee clinical services and health plan total medical spend management;
- Transforming the CHI Management Incentive Program from volume (managed lives) to health outcome improvements (controlled diabetes and hypertensive conditions).

As the healthcare industry evolves to value-based care programs and population health payment arrangements, CHI is building on its CIN-ACO readiness across the country. Several of CHI's CIN-ACO organizations have achieved national ranking. In all CHI markets, the CIN-ACO serves as a regional host to align providers into high performing networks. As appropriate, these networks are forming joint venture partnerships with payers and large employers.

CHI CIN-ACOs are essential to managing the 900,000 contracted lives under value-based arrangements. Within the CIN-ACOs, over 200 clinical care management team members work with the 12,000 CIN-ACO providers (physicians and advanced practice clinicians). Most of these providers are not employed by CHI, rather they have chosen to join its CIN-ACO as their value-based care vehicle.

Additionally, post-acute providers (skilled nursing facilities, home health, hospice) and ancillary providers (physical therapy, laboratories, pharmacies) have joined CHI's CIN-ACOs. These ancillary providers in the network further expedite care transitions, improve care quality and enhance the patient and family experience.

CHI's six Medicare ACOs currently manage $1.4 billion of medical spend for nearly 175,000 Medicare beneficiaries. Mercy ACO in Iowa was CHI's first Medicare ACO to form in 2012. To date, Mercy ACO, Rainier Health Network (WA), Nebraska UniNet and KentuckyOne Health Partners have each driven improved quality outcomes and generated net savings resulting in gain share payments from CMS.

Given the CIN-ACO success with government contracts and in managing its own employee health plan expense, CHI markets are carefully expanding value-based arrangements with payers and employers. By building on these CIN-ACO capabilities and successes, each CHI market further strengthens its role as a key contributor to the health of the communities in which CHI operates.

PART V: STRATEGIC AFFILIATIONS & DIVESTITURES

CHI actively engages in ongoing monitoring and evaluation of potential facility expansion, relationships with academic health center partners, mergers, acquisitions, divestitures, and affiliation opportunities consistent with its strategic goal of creating, maintaining and/or strengthening its clinically integrated networks ("CINs") in key existing markets and, in certain cases, new markets. CHI's strategic vision is supported by focused system growth in both existing and new markets, as evidenced by recent acquisition activity and strategic divestitures, and realignments, certain of which are described below.

A. Pending and Completed Affiliations/Acquisitions/Transactions

CHI - In September 2018, CHI joined with six major, nationally recognized health systems to form Civica Rx, a nonprofit generic drug company that will help patients by addressing shortages and high prices of life saving medications. Once manufacturing approval is obtained from the FDA, Civica Rx will either directly manufacture generic drugs or sub-contract manufacturing with reputable organizations. Its initial goal is to stabilize the supply of essential generic medications administered in hospitals, since many of the medications are in chronic short supply. Civica Rx expects to have its first products on the market as early as 2019.

CHI – Dignity Health Alignment. On December 6, 2017, the Corporation and Dignity Health executed a Ministry Alignment Agreement pursuant to which the Corporation and Dignity Health agreed to align their respective ministries into a single, Catholic, non-profit health system.

Dignity Health owns and operates 39 hospitals in California, Arizona and Nevada and 400+ ancillary care sites across 22 states. As of and for the fiscal year ended June 30, 2017, Dignity Health reported approximately $17.4 billion of total assets, $7.0 billion of net assets and $12.9 billion in total operating revenue.

The new organization will be led by an office of the CEO. Kevin E. Lofton, currently the Chief Executive Officer of CHI and Lloyd Dean, currently the President and Chief Executive Officer of Dignity Health, will both serve as CEOs, each with specific and independent responsibilities and decision-making authority.

The governing board for the new organization, the Board of Stewardship Trustees, will include six members from each legacy board and the two CEOs. The new organization plans to establish its corporate headquarters in Chicago and operate under a new name expected to be chosen in the second half of calendar 2018. Local facilities will continue operating under their current names.

The indebtedness and obligations of the Corporation will remain solely those of the Corporation, secured by and subject to the provisions of its Capital Obligation Document, and the indebtedness and obligations of Dignity Health will remain solely those of Dignity Health, secured by and subject to the provisions of its Master Trust Indenture, until the organizations can be consolidated into a single credit.

The proposed transaction is subject to customary closing conditions, canonical approvals and federal and state regulatory approvals, including the approval of Attorneys General of multiple states. The California approval process involves public meetings, and the California Attorney General may impose conditions to his approval of the proposed transaction. Insurance commissioner approvals are also required in several states. There is no assurance that the closing conditions will be satisfied or such approvals will be received. The parties filed notifications under the Hart-Scott-Rodino Act ("HSR"), and the HSR waiting period expired on April 2, 2018. The parties may close the transaction before April 2, 2019 without having to file another HSR notification.

B. Pending and Completed Divestitures and /or Restructurings

Premier Health Partners Joint Operating Agreement. (the "Premier JOA"). Premier, which was established in 1995 pursuant to the Premier JOA, was responsible for the operational and financial activities of the Premier System, which included CHI's Good Samaritan Hospital located in Dayton, Ohio ("Good Samaritan – Dayton"). The Premier JOA did not provide for or result in an asset merger, and the Corporation therefore retained ownership of the Good Samaritan-Dayton assets.

Effective January 1, 2018, the Corporation entered into an agreement (the "Reorganization Agreement") with Premier Health Partners ("Premier"), an Ohio nonprofit corporation operating various hospitals in southwest Ohio (the "Premier System") and others, to reorganize and restructure Premier from a joint operating company to a joint venture.

Pursuant to the Reorganization Agreement, the Corporation has transferred ownership of the Good Samaritan – Dayton assets and those of its affiliated entities to Premier in exchange for a 22% interest in the restructured Premier joint venture. The Corporation holds an investment in Premier as an unconsolidated organization and reflects the changes in the investment through the statement of operations. There was no gain or loss reported as a result of this transaction.

In July 2018, Premier closed Good Samaritan – Dayton's Philadelphia Drive location, to consolidate its health services at Miami Valley Hospital, which is also now wholly-owned by Premier as a result of the reorganization and located within five miles of the Good Samaritan – Dayton hospital facility. As a result of the Good Samaritan – Dayton's closure, the Corporation expects to defease approximately $40 million of debt with cash by the end of calendar year 2018.

KentuckyOne Health. In November 2012, KentuckyOne entered into a Joint Operating Agreement ("Kentucky JOA") and an Academic Affiliation Agreement ("AAA") (collectively "Agreements") with U of L, University Medical Center, Inc. ("UMC"), which owns the University of Louisville Hospital, and other parties.

Effective June 28, 2018, the sale of the Southern Rehab Hospital to Vibra Healthcare was finalized. Effective On December 17, 2016, KentuckyOne, UMC and U of L agreed to restructure the Kentucky JOA. The operations, management and control of the University of Louisville Hospital was transferred back to UMC effective July 1, 2017. The AAA was also restructured, and various transition services agreements were entered into in connection with the transfer of the University of Louisville Hospital to UMC.

As described in the Annual Report, *Part II: Fiscal Year 2017 Highlights and Summary*, in May 2017, the Corporation approved a plan to sell most or substantially all KentuckyOne's Louisville market acute care operations, including certain entities of Jewish Hospital and St. Mary's Healthcare, Inc. ("JHSMH"). As a result, the Corporation will refocus the Kentucky region on a smaller community footprint, centered in central and eastern Kentucky.

The Corporation assumed complete ownership of KentuckyOne, effective September 1, 2017, when the Corporation purchased the non-controlling interest from the other partner for $150 million in cash consideration.

In December 2017, the Corporation entered into a non-binding letter of intent to negotiate a definitive agreement for the sale of most or substantially all of the KentuckyOne Louisville-area acute care operations, and as a result, CHI recorded impairment charges of $272.0 million for the write-down of assets held for sale to their estimated fair value, less estimated costs to sell, as a result of this anticipated transaction. The impairment charge was recorded as a reduction in net assets through discontinued operations.

In June 2018, an updated non-binding letter of intent for the purchase of JHSMH was received and based upon the terms of that letter of intent, CHI recognized additional impairment charges of $105.5 million in discontinued operations and $11.8 million in continuing operations, to adjust the JHSMH property and equipment values to the lower of their carrying value or their fair value less cost to sell. CHI anticipates closing on a sale during fiscal year 2019.

July 1, 2018, Saint Joseph Martin was sold to Appalachian Regional Healthcare.

The following summarizes selected financial results of UMC and JHSMH included in the CHI consolidated statements of changes in net assets as discontinued operations:

($ in millions)	Twelve Months Ended June 30, 2018	2017	Increase (Decrease)
		Unaudited	
UMC			
Operating revenues	$ -	$ 515.2	N/A
Operating EBIDA before restructuring, impairment and other losses	$ -	$ 47.4	N/A
JHSMH			
Operating revenues	$ 731.8	$ 770.3	$(38.5)
Operating EBIDA before restructuring, impairment and other losses	$(56.9)	$ (44.4)	$(12.5)

The CHI consolidated balance sheets included UMC total assets of $605.5 million and total liabilities of $330.3 million at June 30, 2017. Upon deconsolidation of UMC on July 1, 2017, CHI incurred a loss of $319.2 million recognized in the CHI consolidated statements of changes in net assets. The CHI consolidated balance sheets include JHSMH discontinued operations total assets held for sale of $25.7 million and total liabilities held for sale of $92.4 million at June 30, 2018.

QualChoice. In May 2016, the Corporation approved a plan to sell or otherwise dispose of certain entities of QualChoice, a consolidated CHI subsidiary, whose primary business is to develop, manage and market commercial and Medicare Advantage health insurance programs, as well as a wide range of products and administrative services. In June 2018, the Corporation entered into an asset purchase agreement for the sale of its Medicare Advantage health insurance operations in the State of Washington to be effective in January 2019. In addition, the Corporation also entered into a non-binding letter of intent for the sale of the QualChoice Health commercial operations in the State of Arkansas. Those negotiations related to the QualChoice Health commercial operations are ongoing with the expectation that a purchase agreement will be executed during fiscal year 2019. The Corporation has continued to actively manage QualChoice and has steadily improved operations since the announcement to sell or otherwise dispose of the operations. See *Part IV, Transformative Change Drives Organizational Adaptation-Health Plans* for further description.

The following summarizes the financial results of QualChoice reported in the CHI consolidated statements of changes in net assets:

($ in millions)	Twelve Months Ended June 30, 2018	2017	Increase (Decrease)
QualChoice		Unaudited	
Operating Revenues	$562.3	$576.0	$(15.7)
Operating EBIDA before restructuring, impairment and other losses	$8.6	$(38.6)	$47.2

The June 30, 2018 CHI consolidated balance sheets included the discontinued operations of QualChoice. At June 30, 2018, total assets held for sale were $167.6 million and total liabilities held for sale were $159.3 million.

Real Estate and Other Asset Sales. During fiscal years 2018 and 2017, certain CHI affiliates sold various real estate assets as part of a long-term effort to improve the mix of owned and leased assets. In conjunction with the sale, those CHI affiliates entered into 10-year operating lease agreements with the buyer, and in accordance with ASC 840-40 – Leases – Sale-Leaseback

Transactions, certain of the gains on the sale of the real estate assets were deferred and will be amortized to lease expense over the life of the operating leases.

For fiscal year 2018 and 2017, real estate assets with a net book value of $14.2 million and $281.8 million, respectively, were sold for gross proceeds of $33.6 million and $366.5 million, respectively. As a result of the sale, net of closing costs, CHI recognized $4.0 million and $22.0 million gain on sales in the consolidated statements of operations for the fiscal year ended June 30, 2018 and 2017, respectively. CHI also recorded deferred gains of $15.1 million and $58.0 million for the fiscal year ended June 30, 2018 and 2017, respectively which are being amortized against rent expense over the terms of the respective operating lease agreements.

Pathology Associates Medical Laboratories, LLC (“PAML”). The Corporation owned an interest in PAML, while PAML and certain affiliates of the Corporation owned interests in several joint venture subsidiary entities located in the states of Colorado, Kentucky and Washington. In February 2017, the Corporation and those affiliates entered into a definitive agreement with Laboratory Corporation of America Holdings (“LabCorp”) to sell all such interests in PAML to LabCorp. As of June 30, 2018, the Colorado, Kentucky and Washington transactions have closed. Non-refundable gross sales proceeds attributable to the Corporation and its affiliates of $96.7 million were received in May 2017, resulting in a net gain on sale of $40.2 million.

Additionally, certain affiliates of the Corporation also sold various other ambulatory assets during fiscal year 2017 for net proceeds of $101.7 million reflected within other operating revenues as gain on sale on the consolidated statement of operations for the fiscal year ended June 30, 2017.

PART VI: SELECTED FINANCIAL DATA

The selected financial data that follows has been prepared by management, based on (i) CHI’s unaudited interim financial statements for the three months period ended June 30, 2018 and 2017, and (ii) CHI’s audited financial statements as of and for the fiscal years ended June 30, 2018 and 2017. The unaudited financial statements include all adjustments, consisting of normal recurring accruals, which management of CHI considers necessary for a fair presentation of the combined financial position and results of operations for these periods.

The CHI consolidated financial information should be read in conjunction with the unaudited financial statements, related notes, and other financial information of CHI included in Appendix A of this Annual Report.

The results of operations for recently acquired entities that have been accounted for as acquisitions are included in the CHI consolidated financial and operating information from the respective dates of acquisition.

CHI participates in JOAs with hospital-based organizations in Colorado, Iowa and Ohio. The agreements generally provide for, among other things, joint management of the combined operations of the local facilities included in the JOAs through JOCs. CHI retains ownership of the assets, liabilities, equity, revenues and expenses of the CHI facilities that participate in the JOAs. Transfers of assets from facilities owned by the JOA participants are generally restricted under the terms of the agreements. The financial statements of the CHI facilities managed under all JOAs are included in the CHI consolidated financial statements.

As of June 30, 2018, CHI has investment interests of 65%, 50%, and 50% in JOCs based in Colorado, Iowa, and Ohio, respectively. CHI’s interests in the JOCs are included in investments in unconsolidated organizations and totaled $435.8 million and $381.7 million at June 30, 2018 and 2017, respectively. CHI recognizes its investment in all JOCs under the equity method of accounting. The JOCs provide various levels of services to the related JOA sponsors, and operating expenses of the JOCs are allocated to each sponsoring organization.

Certain joint venture agreements do not result in the consolidation of the jointly owned controlled entities with the Corporation. The results of those operations are instead reflected in the consolidated financial statements of CHI under the line item “Changes in equity of unconsolidated organizations”. Additional detail regarding certain of CHI’s JOAs and investments in Unconsolidated Organizations can be found in Note 3 of the CHI Audited Financial Statements included in Appendix A of this Annual Report.

A. The following table provides condensed consolidated balance sheets as of June 30, 2018 and 2017.

CHI Condensed Consolidated Balance Sheets	*($ in thousands)*	June 30, 2018	2017
Assets		*Unaudited*	
Current assets:			
Cash and equivalents		$ 510,456	$ 810,235
Net patient accounts receivable		2,121,582	2,064,050
Assets of discontinued operations		195,698	1,187,811
Other current assets		764,272	757,938
Total current assets		3,592,008	4,820,034
Investments and assets limited as to use:			
Internally designated investments		5,308,868	5,546,290
Restricted investments		1,163,995	1,211,731
Total investments and assets limited as to use		6,472,863	6,758,021
Property and equipment, net		8,110,767	8,378,161
Other assets		2,419,669	1,975,534
Total assets		$ 20,595,307	$ 21,931,750
Liabilities and net assets			
Current liabilities:			
Accounts payable and accrued expenses		$ 2,181,021	$ 2,274,401
Liabilities of discontinued operations		251,710	492,440
Short-term and current portion of debt		2,184,106	2,112,742
Total current liabilities		4,616,837	4,879,583
Other liabilities		2,504,785	2,798,007
Long-term debt		6,341,931	6,527,426
Total liabilities		13,463,553	14,205,016
Net assets:			
Unrestricted		6,829,063	7,415,388
Temporarily restricted		207,695	214,250
Permanently restricted		94,996	97,096
Total net assets		7,131,754	7,726,734
Total liabilities and net assets		$ 20,595,307	$ 21,931,750

B. The following table presents condensed consolidated statements of operations for the three month periods ended June 30, 2018 and 2017, and fiscal years ended June 30, 2018 and 2017.

CHI Condensed Consolidated Statements of Operations *($ in thousands)*	Three Months Ended June 30, 2018	Three Months Ended June 30, 2017	Fiscal Year Ended June 30, 2018	Fiscal Year Ended June 30, 2017
	Unaudited			
Revenues				
Net patient services revenues	$ 3,527,835	$ 3,484,241	$ 14,136,374	$ 13,962,767
Other	230,788	294,651	845,713	1,079,903
Total operating revenues	3,758,623	3,778,892	14,982,087	15,042,670
Expenses				
Salaries and employee benefits	1,760,141	1,819,151	7,110,519	7,329,717
Supplies, purchased services and other	1,759,815	1,735,600	6,838,039	6,829,086
Depreciation and amortization	218,054	218,274	856,188	824,386
Interest	82,965	73,861	312,771	289,732
Total operating expenses before restructuring, impairment and other losses	3,820,975	3,846,886	15,117,517	15,272,921
Loss from operations before restructuring, impairment and other losses	(62,352)	(67,994)	(135,430)	(230,251)
Restructuring, impairment and other losses	99,633	181,472	141,283	363,191
Loss from operations	(161,985)	(249,466)	(276,713)	(593,442)
Nonoperating gains	45,469	170,139	498,814	704,335
(Deficit) excess of revenues over expenses	$ (116,516)	$ (79,327)	$ 222,101	$ 110,893

1. CRITICAL ACCOUNTING POLICIES

The preparation of financial statements in conformity with GAAP requires that management make assumptions, estimates and judgments affecting the amounts reported in the financial statements, including the notes thereto, and related disclosures of commitments and contingencies, if any. Management considers critical accounting policies to be those that require more significant judgments and estimates in the preparation of its financial statements, including the following: recognition of net patient services revenues, which includes contractual allowances, bad debt and charity care reserves; cost report settlements; impairment of goodwill, intangibles and long-lived assets; provisions for bad debt; valuations of investments; and reserves for losses and expenses related to health care professional and general liability risks. In making such judgments and estimates, management relies on historical experience and on other assumptions believed to be reasonable under the circumstances. Actual results could differ materially from the estimates. A description of CHI's significant accounting policies can be found in Note 1 of the CHI Audited Financial Statements included in Appendix A of this Annual Report.

PART VII: MANAGEMENT'S DISCUSSION & ANALYSIS

The following table provides key balance sheet metrics as of June 30, 2018 and 2017.

CHI Key Balance Sheet Metrics	June 30, 2018 *Unaudited*	June 30, 2017
Consolidated Balance Sheet Summary		
Total assets	$ 20.6 billion	$ 21.9 billion
Total liabilities	$ 13.5 billion	$ 14.2 billion
Total net assets	$ 7.1 billion	$ 7.7 billion
Financial Position and Leverage Ratios (Unaudited)		
Total cash and unrestricted investments	$ 5.8 billion	$ 6.4 billion
Days of cash on hand[1]	149	161
Total debt	$ 8.5 billion	$ 8.6 billion
Debt to capitalization[2]	55.5%	53.8%
Debt to cash flow[3]	14.5x	26.2x
Historical Debt Service Coverage Ratio	3.3x	2.5x

[1] (Cash and equivalents + Investments and assets limited as to use: Internally designated investments)/((Total operating expenses before restructuring, impairment and other losses - Depreciation and amortization)/365). For the days of cash on hand one day of operating expenses represented $39.1 million at June 30, 2018 and $39.6 million at June 30, 2017.

[2] (Short-term and current portion of debt + Long-term debt)/(Short-term and current portion of debt + Long-term debt + Unrestricted net assets).

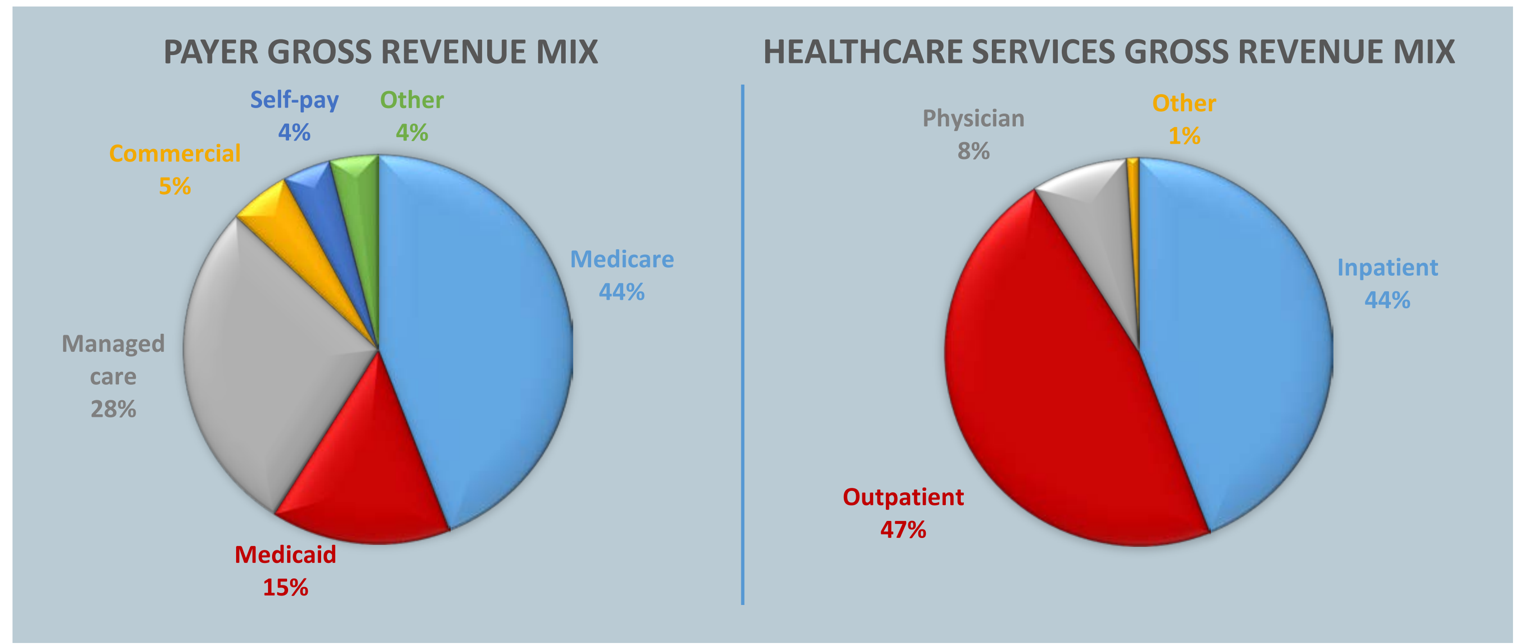
[3] (Short-term and current portion of debt + Long-term debt)/(Loss from operations + Depreciation and amortization + Non-cash restructuring, impairment and other losses + Net periodic pension expense (income)).

The following table presents key operating metrics and utilization statistics for the three months ended June 30, 2018 and 2017, and fiscal years ended June 30, 2018 and 2017.

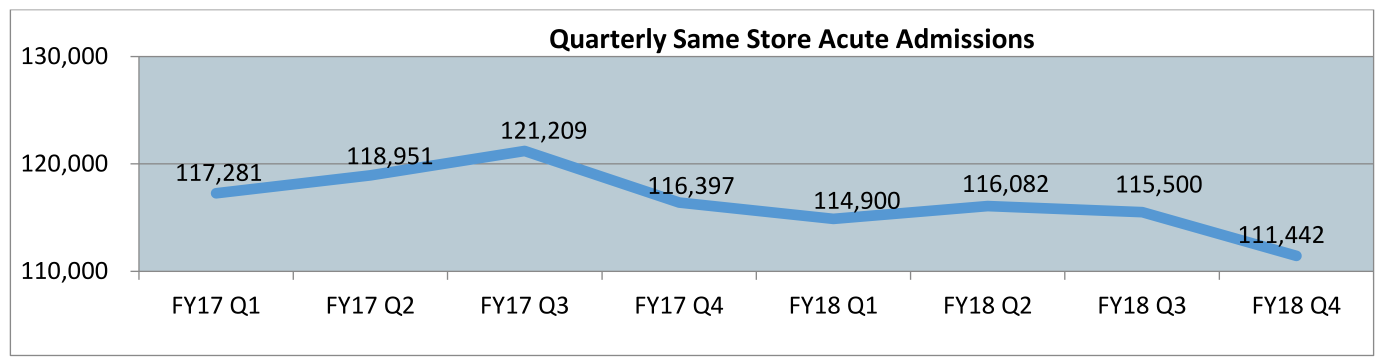
CHI Key Operating Metrics and Utilization Statistics	Three Months Ended June 30, 2018	Three Months Ended June 30, 2017	Fiscal Year Ended June 30, 2018	Fiscal Year Ended June 30, 2017
		Unaudited		
Consolidated Revenues, Expenses and Key Operating Metrics*				
Total net patient services revenues	$ 3.5 billion	$ 3.5 billion	$ 14.1 billion	$ 14.0 billion
Total operating revenues	$ 3.8 billion	$ 3.8 billion	$ 15.0 billion	$ 15.0 billion
Total operating expenses before restructuring, impairment and other losses	$ 3.8 billion	$ 3.8 billion	$ 15.1 billion	$ 15.3 billion
Operating EBIDA before restructuring, impairment and other losses[1]	$ 238.7 million	$ 224.1 million	$ 1,033.5 million	$ 883.9 million
Operating EBIDA margin before restructuring, impairment and other losses[2]	6.3%	5.9%	6.9%	5.9%
Operating loss before restructuring, impairment and other losses	$ (62.4) million	$ (68.0) million	$ (135.4) million	$ (230.3) million
Operating loss margin before restructuring, impairment and other losses[3]	(1.7)%	(1.8)%	(0.9)%	(1.5)%
Operating EBIDA[4]	$ 139.0 million	$ 42.7 million	$ 892.2 million	$ 520.7 million
Operating EBIDA margin[5]	3.7%	1.1%	6.0%	3.5%
Operating loss	$ (162.0) million	$ (249.5) million	$ (276.7) million	$ (593.4) million
Operating loss margin[6]	(4.3)%	(6.6)%	(1.8)%	(3.9)%
Net (loss) income[7]	$ (116.5) million	$ (79.3) million	$ 222.1 million	$ 110.9 million
Net (loss) income margin[8]	(3.1)%	(2.0)%	1.4%	0.7%
Utilization Statistics				
Acute admissions	111,442	120,170	464,717	488,821
Acute inpatient days	522,572	550,125	2,176,954	2,274,881
Acute average length of stay in days	4.7	4.6	4.7	4.7
Long-term care days	111,736	116,968	422,069	483,151
Medicare case-mix index	1.9	1.8	1.9	1.8
Adjusted admissions[9]	257,529	268,980	1,046,800	1,081,115
Inpatient ER visits	62,633	65,003	256,642	263,209
Inpatient surgeries	34,032	37,064	142,272	149,670
Outpatient ER visits	449,305	466,486	1,849,152	1,911,854
Outpatient non-ER visits	1,346,328	1,434,473	5,408,771	5,699,575
Outpatient surgeries	59,630	61,238	236,617	247,641
Physician visits	2,730,907	2,725,679	10,949,019	10,540,482

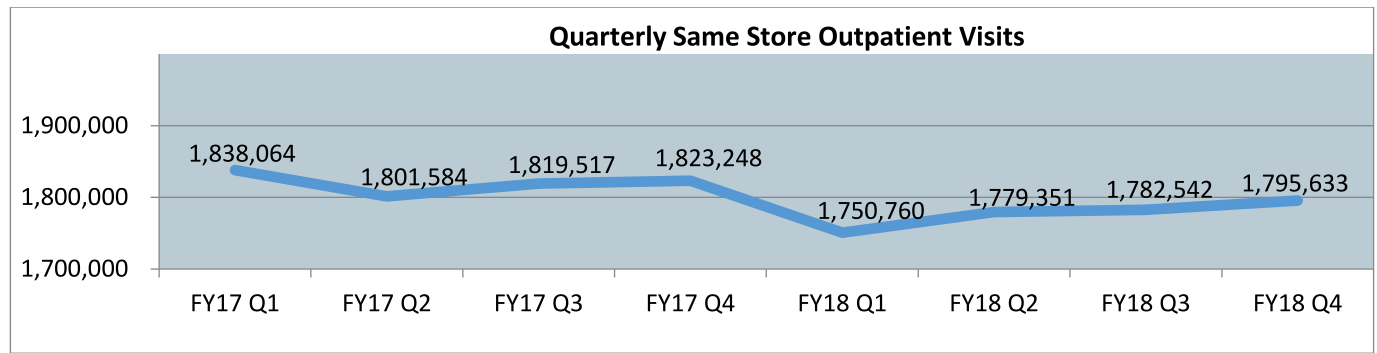
* Includes business combination gains.
[1] Income (loss) from operations before restructuring, impairment and other losses + depreciation and amortization + interest.
[2] Income (loss) from operations before restructuring, impairment and other losses + depreciation and amortization + interest/total operating revenues.
[3] Income (loss) from operations before restructuring, impairment and other losses/total operating revenues.
[4] Income (loss) from operations + depreciation and amortization + interest.
[5] Income (loss) from operations + depreciation and amortization + interest/total operating revenues.
[6] Income (loss) from operations/total operating revenues.
[7] Excess (deficit) of revenues over expenses
[8] Excess (deficit) of revenues over expenses/(total operating revenues + nonoperating gains (losses).
[9] (Total gross patient revenues/total gross inpatient revenues) x acute admissions.

The following charts represent the payer gross revenue mix and healthcare services gross revenue mix for the consolidated operations for the fiscal year ended June 30, 2018.



The following charts represent quarterly patient volume activity for the consolidated operations over the previous eight quarters.





1. SUMMARY OF OPERATING RESULTS FOR THE THREE MONTHS ENDED JUNE 30, 2018 AND 2017

OPERATING EBIDA/LOSS FROM OPERATIONS

Operating EBIDA before restructuring, impairment and other losses, excluding transactional gains and other items, improved $53.2 million for the three months ended June 30, 2018, compared to the three months ended June 30, 2017, due to increased net patient services revenues combined with favorable expense management. Loss from operations before restructuring, impairment and other losses, excluding transactional gains and other items, improved $44.2 million for the three months ended June 30, 2018, compared to the three months ended June 30, 2017.

Same store net patient services revenues per adjusted admission was $13,699 for the three months ended June 30, 2018, compared to $13,036 for the three months ended June 30, 2017, or a $663 and 5.1% increase, whereas same store expenses per adjusted admissions before restructuring was $14,837 for the three months ended June 30, 2018, compared to $14,430 for the three months ended June 30, 2017, or a $407 and 2.8% increase. Same store total net patient services revenues increased $131.0 million, or 3.9%. Impacting same store net patient services revenues were $141.1 million in contract rate increases and other improvements, increases in acuity of $42.6 million, and provider fee revenue improvements of $16.6 million, offset by volume decreases of $69.3 million. Same store total operating expenses increased $61.0 million, or 1.6%, which included inflationary increases as well as increased supplies and medical professional fees expenses, which were partially offset by decreases in labor and purchased services expenses as a result of favorable expense management.

Operating EBIDA before restructuring, impairment and other losses, excluding transactional gains and other items, is as follows:

($ in millions)	Three Months Ended June 30, 2018	2017	Increase
	Unaudited		
Operating EBIDA before restructuring, impairment and other losses, excluding transactional gains and other items	$235.1	$181.9	$53.2
Operating EBIDA margin before restructuring, impairment and other losses, excluding transactional gains and other items	6.3%	4.9%	
Ohio compliance adjustment[1]	3.6	-	
Gain on sale of lab operations[2]	-	40.2	
Gains on real estate sales	-	2.0	
Operating EBIDA before restructuring, impairment and other losses	$238.7	$224.1	$14.6
Operating EBIDA margin before restructuring, impairment and other losses	6.3%	5.9%	

[1] Related to a reimbursement documentation matter.

[2] Related to gains recognized from CHI's interest in PAML as well as CHI's interests in several PAML joint ventures.

Operating loss before restructuring, impairment and other losses, excluding transactional gains and other items, is as follows:

($ in millions)	Three Months Ended June 30, 2018	2017	Increase
	Unaudited		
Operating loss before restructuring, impairment and other losses, excluding transactional gains and other items	$(66.0)	$(110.2)	$44.2
Operating loss margin before restructuring, impairment and other losses, excluding transactional gains and other items	(1.8)%	(2.9)%	
Ohio compliance adjustment[1]	3.6	-	
Gain on sale of lab operations[2]	-	40.2	
Gains on real estate sales	-	2.0	
Operating income (loss) before restructuring, impairment and other losses	$(62.4)	$(68.0)	$5.6
Operating income (loss) margin before restructuring, impairment and other losses	(1.7)%	(1.8)%	

[1] Related to a reimbursement documentation matter.

[2] Related to gains recognized from CHI's interest in PAML as well as CHI's interests in several PAML joint ventures.

Operating EBIDA before restructuring, impairment and other losses, excluding transactional gains and other items, over the trailing four quarters is as follows:

($ in millions)	QTD 6/30/2018	QTD 3/31/2018	QTD 12/31/2017	QTD 9/30/2017
	Unaudited			
Operating EBIDA before restructuring, impairment and other losses, excluding transactional gains and other items	$235.1	$259.8	$298.1	$226.8
Operating EBIDA margin before restructuring, impairment and other losses, excluding transactional gains and other items	6.3%	7.0%	7.8%	6.2%
Nebraska net patient services revenue adjustments[1]	-	-	-	13.6
Ohio compliance adjustment[2]	3.6	-	-	(7.4)
Gains on real estate sales	-	-	-	4.0
Operating EBIDA before restructuring, impairment and other losses	$238.7	$259.8	$298.1	$237.0
Operating EBIDA margin before restructuring, impairment and other losses	6.3%	7.0%	7.8%	6.4%

[1] Related to favorable bad debt adjustments.

[2] Related to a reimbursement documentation matter.

The table below presents various regional financial metrics for CHI for the three months ended June 30, 2018 and 2017. Further information on CHI's regional operating results is discussed within the regional operating trends section below.

Catholic Health Initiatives Operations Summary – Three Months Ended June 30, 2018 and 2017

Region	QTD 6/30/2018 Operating EBIDA before restructuring, impairment and other losses	QTD 6/30/2017 Operating EBIDA before restructuring, impairment and other losses	QTD 6/30/2018 Operating EBIDA margin before restructuring, impairment and other losses	QTD 6/30/2017 Operating EBIDA margin before restructuring, impairment and other losses	QTD 6/30/2018 Operating revenues percentage of CHI consolidated	QTD 6/30/2017 Operating revenues percentage of CHI consolidated
	($ in thousands)		*Unaudited*			
Pacific Northwest	$ 67,592	$ 84,523	9.6%	12.3%	18.7%	18.1%
Colorado	89,988	96,814	15.0%	15.9%	15.9%	16.1%
Texas	25,819	1,505	4.5%	0.3%	15.4%	14.4%
Nebraska	62,886	31,492	11.8%	6.2%	14.2%	13.5%
Kentucky	10,325	34,832	4.2%	11.9%	6.6%	7.7%
Iowa	10,521	11,543	4.0%	4.5%	7.0%	6.8%
Ohio	(1,180)	17,508	(0.6)%	6.2%	5.3%	7.5%
Arkansas	(7,396)	1,969	(3.8)%	1.0%	5.2%	5.1%
North Dakota/Minnesota	11,417	1,508	6.2%	0.8%	4.9%	4.8%
Tennessee	6,319	12,012	3.7%	7.5%	4.5%	4.2%
National business lines[1]	7,631	11,981	8.5%	15.7%	2.4%	2.0%
Other[2]	(425)	(7,051)	N/A	N/A	(0.1)%	(0.2)%
Total Regional	283,497	298,636	7.5%	7.9%	100.0%	100.0%
Corporate services and other business lines[3]	(44,830)	(74,495)	N/A	N/A	0.0%	0.0%
Total CHI Consolidated	$ 238,667	$ 224,141	6.3%	5.9%	100.0%	100.0%

[1] Includes Home Care and Senior Living business lines.
[2] Includes the operations of Albuquerque Health Ministries and Lancaster Health Ministries MBOs as well as regional eliminations.
[3] Includes CHI Corporate and First Initiatives Insurance, Ltd. ("FIIL"), CHI's wholly-owned captive insurance company as well as CHI system eliminations.

OPERATING REVENUE AND VOLUME TRENDS

Same store total operating revenue, net patient services revenues, and other operating revenue changes are summarized below. Normalized amounts have been adjusted to exclude transactional gains and other items as noted above.

Three Months Ended June 30, 2018 Compared to Three Months Ended June 30, 2017

Same Store Revenue	2018	2017	Increase (Decrease)
($ In millions)	*Unaudited*		
Net patient services revenues	$3,527.8	$3,396.9	$ 130.9
Other operating revenue	242.7	300.3	(57.6)
Total operating revenue	$3,770.5	$3,697.2	$73.3
Net patient services revenues normalized[1]	3,522.7	3,396.9	125.8
Other operating revenue normalized[2]	244.2	258.2	(14.0)
Total operating revenue normalized	$3,766.9	$3,655.1	$111.8

[1] Excludes the $5.1 million Ohio favorable reimbursement documentation matter impact for the three months ended June 30, 2018.
[2] Excludes the $1.5 million unfavorable JOA income share impact as a result of the Ohio reimbursement documentation matter for the three months ended June 30, 2018, the $40.2 million gain on sale of lab operations from CHI's interest in PAML as well as CHI's interests in several PAML joint ventures for the three months ended June 30, 2017 and the $2.0 million in real estate gains for the three months ended June 30, 2017.

Same store other operating revenues, adjusted to exclude transactional gains and other items, have decreased $14.0 million for the three months ended June 30, 2018, compared to the three months ended

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June 30, 2017, due primarily to clinical engineering support provided to external parties.

Same store patient volume increases (decreases) are summarized below.

Three Months Ended June 30, 2018 Compared to Three Months Ended June 30, 2017

Same Store Patient Volumes	Increase (Decrease)	Increase (Decrease)
	Unaudited	
Adjusted Admissions	(1.2)%	(3,037)
Acute Admissions	(4.3)%	(4,955)
Acute Inpatient Days	(2.4)%	(12,725)
Inpatient ER Visits	(3.6)%	(2,370)
Inpatient Surgeries	(6.2)%	(2,266)
Outpatient ER Visits	0.7%	3,052
Outpatient Non-ER Visits	(2.2)%	(30,667)
Outpatient Surgeries	0.7%	438
Physician Visits	0.2%	5,228

OPERATING EXPENSES

Increases (decreases) in same store total operating expenses before restructuring, impairment and other losses are summarized below.

Three Months Ended June 30, 2018 Compared to Three Months Ended June 30, 2017

Same Store Expense	2018	2017	Increase (Decrease)
	($ In millions)		
	Unaudited		
Total labor	$1,760.1	$1,773.4	$(13.3)
Supplies	614.5	589.8	24.7
Purchased services	431.8	440.	(8.7)
Medical professional fees	139.5	122.8	16.7
Interest	83.0	74.2	8.8
Depreciation and amortization	218.1	210.9	7.2
All other	574.0	548.4	25.6
Total operating expenses	$3,821.0	$3,760.0	$61.0

Same store labor and supply indicators are summarized below.

Three Months Ended June 30, 2018 Compared to Three Months Ended June 30, 2017

Same store labor and supply indicators	2018	2017
	Unaudited	
Labor % of net patient services revenues	49.9%	52.2%
Labor % of total operating expense	46.1%	47.2%
Supplies % of net patient services revenues	17.4%	17.4%
Supplies % of total operating expense	16.1%	15.7%

Reductions in same store total labor costs and purchased services for the three months ended June 30, 2018, were a result of strategic initiatives to reduce overall expenses across CHI as described in more detail below.

Same store total labor costs decreased $13.3 million for the three months ended June 30, 2018, compared to the three months ended June 30, 2017, due to a decrease in FTEs of 611 or $14.9 million, offset by an increase in average hourly rates of $1.6 million. CHI continues to address labor productivity within the regions, as well as growth initiatives in certain physician practices where labor costs have been added in anticipation of future increased patient volumes.

Same store medical professional fees increased $16.7 million, or 13.6%, for the three months ended June 30, 2018, compared to the three months ended June 30, 2017, due to the movement of certain employed physicians to a professional fee contract model primarily in the Texas region.

Same store supplies as a percentage of net patient services revenues were 17.4% for the three months ended June 30, 2018 and 2017, and included $14.8 million in increased medical surgical utilization supplies expenses and $9.9 million in increased pharmacy supplies expenses.

REGIONAL OPERATING TRENDS

The Corporation periodically reviews its allocation methodology for corporate support services and may adjust those allocations based on the strategic needs and resource consumption of the regions and CHI overall. These changes in allocation methodologies

may increase or decrease a region's operating results from year to year, but have no impact on the consolidated results of CHI.

The Pacific Northwest, Colorado, Texas, Nebraska and Kentucky regions represent CHI's five largest operating regions, and for the three months ended June 30, 2018, represented 70.8% of CHI's consolidated operating revenues. Additional information on these regions is discussed below.

Pacific Northwest - the region's operating EBIDA before restructuring, impairment and other losses totaled $67.6 million for the three months ended June 30, 2018, and decreased $16.9 million, compared to the three months ended June 30, 2017. Results included a $14.9 million gain on sale of interests in various laboratory operations for the three months ended June 30, 2017. Net patient services revenues increased $30.9 million for the three months ended June 30, 2018, compared to the three months ended June 30, 2017, and included $28.1 million in favorable contract increases and other items and favorable increases in volume of $2.8 million. Increased operating expenses of $41.0 million exceeded the growth in net patient services revenues for the three months ended June 30, 2018, compared to the three months ended June 30, 2017. The increase in operating expenses was primarily a result of increased compensation, inflation increases, and depreciation increases. Depreciation and amortization expenses increased $6.4 million, or 20.0% for the three months ended June 30, 2018, compared to the three months ended June 30, 2017, due to facility expansion and renovation activities which has increased capitalized assets and related depreciation.

Total net revenue per adjusted admission increased 4.0% for the three months ended June 30, 2018, compared to the three months ended June 30, 2017, while total operating expense per adjusted admission increased 5.6% for the three months ended June 30, 2018, compared to the three months ended June 30, 2017. Total labor as a percentage of net patient services revenues was 51.3% for the three months ended June 30, 2018 and 2017. Supply expense as a percentage of net patient services revenues increased to 13.6% for the three months ended June 30, 2018, compared to 13.2% for the three months ended June 30, 2017, which represents an unfavorable expense variance of $2.4 million.

Colorado - the region's operating EBIDA before restructuring, impairment and other losses totaled $90.0 million for the three months ended June 30, 2018 and decreased $6.8 million compared to the three months ended June 30, 2017. Results included a $10.3 million gain on sale of interests in various laboratory operations for the three months ended June 30, 2017. Net patient services revenues decreased $6.5 million for the three months ended June 30, 2018, compared to the three months ended June 30, 2017, due to decreases in volume of $25.1 million, offset by increases in acuity of $10.8 million, provider fee increases of $5.7 million, and $2.1 million in favorable contract increases and other items. Operating expenses decreased $4.2 million for the three months ended June 30, 2018, compared to the three months ended June 30, 2017, due to continued implementation of expense management and productivity improvements.

Total net revenue per adjusted admission increased 3.1% for the three months ended June 30, 2018, compared to the three months ended June 30, 2017, while total operating expense per adjusted admission increased 3.6% for the three months ended June 30, 2018, compared to the three months ended June 30, 2017. Total labor as a percentage of net patient services revenues decreased to 38.3% for the three months ended June 30, 2018, compared to 41.8% for the three months ended June 30, 2017, representing a favorable expense variance of $18.7 million. Supply expense as a percentage of net patient services revenues increased to 15.5% for the three months ended June 30, 2018, compared to 14.9% for the three months ended June 30, 2017, which represents an unfavorable expense variance of $3.6 million.

Texas - the region's operating EBIDA before restructuring, impairment and other losses totaled $25.8 million for the three months ended June 30, 2018 and increased $24.3 million compared to the three months ended June 30, 2017. Net patient services revenues increased $37.1 million for the three months ended June 30, 2018, compared to the three months ended June 30, 2017, and included $14.8 million favorable contract rate increases and other items, state program reimbursement increases of $12.4 million, and

$9.9 million in favorable acuity shifts. The growth in net patient services revenues exceeded the increase in operating expenses of $12.2 million for the three months ended June 30, 2018, compared to the three months ended June 30, 2017, due to continued implementation of expense management and productivity improvements.

Total net revenue per adjusted admission increased 7.0% for the three months ended June 30, 2018, compared to the three months ended June 30, 2017, while total operating expense per adjusted admission increased 2.1% for the three months ended June 30, 2018, compared to the three months ended June 30, 2017. Total labor as a percentage of net patient services revenues decreased to 41.0% for the three months ended June 30, 2018, compared to 45.9% for the three months ended June 30, 2017, representing a favorable expense variance of $27.3 million. However, medical professional fees expense increased $12.7 million and purchased services expense increased $17.5 million for the three months ended June 30, 2018, compared to the three months ended June 30, 2017, due to a shift in classification of certain services and physician compensation arrangements. Supply expense as a percentage of net patient services revenues increased to 20.5% for the three months ended June 30, 2018, compared to 19.8% for the three months ended June 30, 2017, representing an unfavorable expense variance of $3.7 million. Management is continuing to implement strategies to improve labor productivity, supply chain, and overall expense savings in the Texas region.

Nebraska - the region's operating EBIDA before restructuring, impairment and other losses totaled $62.9 million for the three months ended June 30, 2018, and increased $31.4 million compared to the three months ended June 30, 2017. Net patient services revenues increased $32.7 million for the three months ended June 30, 2018, compared to the three months ended June 30, 2017, and included $20.0 million in favorable contract rate increases and other items, $13.5 million in updated cost report and compliance reserve estimates, and favorable shifts in acuity of $5.6 million, offset by decreases in volume of $6.4 million.

Total net revenue per adjusted admission increased 8.1% for the three months ended June 30, 2018, compared to the three months ended June 30, 2017, while total operating expense per adjusted admission increased 0.6% for the three months ended June 30, 2018, compared to the three months ended June 30, 2017. Total operating expenses decreased $2.1 million for the three months ended June 30, 2018, compared to the three months ended June 30, 2017, due to continued implementation of expense management and productivity improvements. Total labor as a percentage of net patient services revenues decreased to 54.0% for the three months ended June 30, 2018, compared to 55.9% for the three months ended June 30, 2017, representing a favorable expense variance of $9.4 million. Supply expense as a percentage of net patient services revenues decreased to 14.3% for the three months ended June 30, 2018, compared to 16.4% for the three months ended June 30, 2017, representing a favorable expense variance of $10.5 million.

Kentucky - the region's operating EBIDA before restructuring, impairment and other losses (excluding discontinued operations) totaled $10.3 million for the three months ended June 30, 2018 and decreased $24.5 million compared to the three months ended June 30, 2017. Net patient services revenues decreased $31.6 million for the three months ended June 30, 2018, compared to the three months ended June 30, 2017, and included volume decreases of $32.5 million and unfavorable shifts in payer mix of $1.0 million, offset by $1.9 million in favorable contract rate increases and other items. Total operating expenses decreased $23.6 million for the three months ended June 30, 2018, compared to the three months ended June 30, 2017, due to continued expense management and labor productivity improvements across the region.

Total net revenue per adjusted admission decreased 4.5% for the three months ended June 30, 2018, compared to the three months ended June 30, 2017, while total operating expense per adjusted admission decreased 0.6% for the three months ended June 30, 2018, compared to the three months ended June 30, 2017. Total labor as a percentage of net patient services revenues increased to 49.7% for the three months ended June 30, 2018, compared to 48.6% for the three months ended June 30, 2017, representing an unfavorable expense variance of $2.3 million. Supply expense as a percentage of net patient services

revenues increased to 20.3% for the three months ended June 30, 2018, compared to 17.2% for the three months ended June 30, 2017, representing an unfavorable expense variance of $6.9 million.

CHI Corporate services and other business lines - operating EBIDA before restructuring, impairment and other losses totaled $44.8 million, an improvement of $29.7 million for the three months ended June 30, 2018, compared to the three months ended June 30, 2017. Margin improvements include focused cost reductions in all support services and include $9.0 million related to information technology services, $13.5 million in reductions for National support services, and $7.2 million related to self-insurance welfare benefit programs. Changes in support services activities relate to a variety of factors and include strategic transfers of support activities from the regions and other service lines to corporate services to build corporate support functions, and new implementations of system-wide services. Support services allocations to the regions consider the strategic needs and resource consumption of the regions and CHI overall. Expense decreases have occurred within various support services concentrated within Information Technology, Clinical Engineering and Onshore Risk and Insurance.

Restructuring, Impairment and Other Losses

($ in thousands)	Three Months Ended June 30, 2018	2017
	Unaudited	
Changes in business operations	$ 14,563	$ 119,190
Severance costs	20,106	21,687
Impairment charges	11,765	917
Pension settlement costs	53,199	39,678
Total restructuring, impairment and other losses	$ 99,633	$ 181,472
Non-cash expenses related to restructuring, impairment and other losses	$ 64,976	$ 102,697

Restructuring, impairment, and other losses include charges relating to changes in business operations, severance costs, EPIC go-live support costs, goodwill impairments, acquisition-related costs, and pension settlement activity. Changes in business operations include costs incurred periodically to implement reorganization efforts within specific operations to align CHI's operations in the most strategic and cost-effective manner. The non-cash portion of total restructuring, impairment and other losses includes impairment charges, pension settlement costs, and project cost abandonment charges included in changes in business operations.

Nonoperating Results

($ in thousands)	Three Months Ended June 30, 2018	2017
	Unaudited	
Investment income, net	$ 37,436	$ 186,066
Losses on early extinguishment of debt	-	(3,402)
Realized and unrealized gains (losses) on interest rate swaps	12,063	(13,444)
Other nonoperating (losses) gains	(4,030)	919
Total nonoperating gains	$ 45,469	$ 170,139

2. SUMMARY OF OPERATING RESULTS FOR FISCAL YEARS ENDED JUNE 30, 2018 AND 2017

OPERATING EBIDA/LOSS FROM OPERATIONS

Operating EBIDA before restructuring, impairment and other losses, excluding transactional gains and other items, improved $255.7 million for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30, 2017, due to increased net patient services revenues combined with favorable expense management. Loss from operations before restructuring, impairment and other losses, excluding

transactional gains and other items, improved $221.1 million for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30, 2017.

Same store net patient services revenues per adjusted admission was $13,548 for the fiscal year ended June 30, 2018, compared to $12,990 for the fiscal year ended June 30, 2017, or a $558 and 4.3% increase, whereas same store expenses per adjusted admissions before restructuring was $14,478 for the fiscal year ended June 30, 2018, compared to $14,231 for the fiscal year ended June 30, 2017, or a $247 and 1.7% increase. Same store total net patient services revenues, excluding transactional gains and other items, increased $327.6 million, or 2.4%. Impacting same store net patient services revenues were $348.5 million in contract rate increases and other improvements, increases in acuity of $53.7 million, $36.7 million increase to net revenue due to accounts receivable reserve changes between years, and provider fee revenue improvements of $23.0 million, offset by volume decreases of $111.6 million and decreases of $22.7 million related to payer mix shifts. Same store total operating expenses increased $23.5 million, or 0.2%, which included decreases in labor and purchased services expenses due to favorable expense management, offset by increases in supplies and medical professional fees expenses.

Operating EBIDA before restructuring, impairment and other losses, excluding transactional gains and other items, is as follows:

	Twelve Months Ended June 30,		
($ in millions)	2018	2017	Increase
	Unaudited		
Operating EBIDA before restructuring, impairment and other losses, excluding transactional gains and other items	$1,019.7	$764.0	$255.7
Operating EBIDA margin before restructuring, impairment and other losses, excluding transaction gains and other items	6.8%	5.1%	
Nebraska net patient services revenue adjustments[1]	13.6	(28.0)	
Ohio compliance adjustment[2]	(3.8)	-	
Net gain on ambulatory sale[3]	-	85.7	
Gain on sale of lab operations[4]	-	40.2	
Gains on real estate sales	4.0	22.0	
Operating EBIDA before restructuring, impairment and other losses	$1,033.5	$883.9	$149.6
Operating EBIDA margin before restructuring, impairment and other losses	6.9%	5.9%	

[1] Related to favorable bad debt adjustments for the twelve months ended June 30, 2018 and unfavorable revenue adjustments for the twelve months ended June 30, 2017.
[2] Related to an unfavorable reimbursement documentation matter.
[3] Related to net favorable results primarily from the sale of certain outpatient ambulatory business lines in the Pacific Northwest region.
[4] Related to gains recognized from CHI's interest in PAML as well as CHI's interest's in several PAML joint ventures.

This document is dated as of September 28, 2018

Operating loss before restructuring, impairment and other losses, excluding transactional gains and other items, is as follows:

($ in millions)	Twelve Months Ended June 30, 2018	2017 Unaudited	Increase
Operating loss before restructuring, impairment and other losses, excluding transactional gains and other items	$(129.1)	$(350.2)	$221.1
Operating loss margin before restructuring, impairment and other losses, excluding transactional gains and other items	(0.9)%	(2.3)%	
Nebraska net patient services revenue adjustments[1]	13.6	(28.0)	
Ohio compliance adjustment[2]	(3.8)	-	
Net gain on ambulatory sale[3]	-	85.7	
Gain on sale of lab operations[4]	-	40.2	
Gains on real estate sales	4.0	22.0	
Depreciation increase on IT assets due to change in useful life	(20.1)	-	
Operating loss before restructuring, impairment and other losses	$(135.4)	$(230.3)	$94.9
Operating loss margin before restructuring, impairment and other losses	(0.9)%	(1.5)%	

[1] Related to favorable bad debt adjustments for the twelve months ended June 30, 2018, and unfavorable revenue adjustments for the twelve months ended June 30, 2017.
[2] Related to an unfavorable reimbursement documentation matter.
[3] Related to net favorable results primarily from the sale of certain outpatient ambulatory business lines in the Pacific Northwest region.
[4] Related to gains recognized from CHI's interest in PAML as well as CHI's interests in several PAML joint ventures.

The table below presents various regional financial metrics for CHI for the twelve months ended June 30, 2018 and 2017. Further information on CHI's regional operating results is discussed within the regional operating trends section below.

Catholic Health Initiatives Operations Summary – Twelve Months Ended June 30, 2018 and 2017

Region ($ in thousands)	6/30/2018 Operating EBIDA before restructuring, Impairment and other losses	6/30/2017 Operating EBIDA before restructuring, Impairment and other losses	6/30/2018 Operating EBIDA margin before restructuring, Impairment and other losses (Unaudited)	6/30/2017 Operating EBIDA margin before restructuring, Impairment and other losses (Unaudited)	6/30/2018 Operating revenues percentage of CHI consolidated	6/30/2017 Operating revenues percentage of CHI consolidated
Pacific Northwest	$ 292,130	$ 369,519	10.6%	13.4%	18.4%	18.4%
Colorado	318,416	275,949	13.2%	11.7%	16.1%	15.6%
Texas	84,334	64,332	3.8%	3.0%	14.9%	14.4%
Nebraska	238,336	106,715	11.4%	5.3%	13.9%	13.5%
Kentucky	89,103	68,758	8.4%	6.2%	7.1%	7.4%
Iowa	43,630	62,561	4.3%	6.1%	6.8%	6.8%
Ohio	26,477	89,551	2.7%	7.8%	6.4%	7.7%
Arkansas	(13,577)	10,885	(1.8)%	1.4%	5.1%	5.1%
North Dakota/Minnesota	58,864	38,420	8.0%	5.1%	4.9%	5.0%
Tennessee	55,052	59,239	8.1%	9.0%	4.5%	4.4%
National business lines[1]	31,304	28,201	9.5%	9.9%	2.2%	1.9%
Other[2]	(42,028)	(35,054)	N/A	N/A	(0.3)%	(0.2)%
Total Regional	1,182,041	1,139,076	7.9%	7.6%	100.0%	100.0%
Corporate services and other business lines[3]	(148,512)	(255,209)	N/A	N/A	0.0%	0.0%
Total CHI Consolidated	$ 1,033,529	$ 883,867	6.9%	5.9%	100.0%	100.0%

[1] Includes Home Care and Senior Living business lines.
[2] Includes the operations of Albuquerque Health Ministries and Lancaster Health Ministries MBOs as well as regional eliminations.
[3] Includes CHI Corporate and First Initiatives Insurance, Ltd. ("FIIL"), CHI's wholly-owned captive insurance company as well as CHI system eliminations.

OPERATING REVENUE AND VOLUME TRENDS

Same store total operating revenue, net patient services revenues, and other operating revenue changes are summarized below. Normalized amounts have been adjusted to exclude transactional gains and other items as noted above.

Twelve Months Ended June 30, 2018 Compared to Twelve Months Ended June 30, 2017

($ In millions) Same Store Revenue	2018	2017	Increase (Decrease)
	Unaudited		
Net patient services revenues	$13,973.8	$13,609.5	$ 364.3
Other operating revenue	864.8	1,086.8	(222.0)
Total operating revenue	$14,838.6	$14,696.3	$142.3
Net patient services revenues normalized[1]	13,965.1	13,637.5	327.6
Other operating revenue normalized[2]	859.7	922.9	(63.2)
Total operating revenue normalized	$14,824.8	$14,560.4	$264.4

[1] Excludes the $13.6 million Nebraska favorable bad debt adjustments for the twelve months ended June 30, 2018, the $28.0 million Nebraska unfavorable net revenue adjustments for the twelve months ended June 30, 2017, and the $4.9 million Ohio unfavorable reimbursement documentation matter impact for the twelve months ended June 30, 2018.

[2] Excludes the $1.1 million favorable JOA income share impact as a result of the Ohio reimbursement documentation matter for the twelve months ended June 30, 2018, the $101.7 million gain recognized from the sale of certain outpatient ambulatory business lines in the Pacific Northwest region for the twelve months ended June 30, 2017, and the $4.0 million and $22.0 million real estate gains for the twelve months ended June 30, 2018 and 2017, respectively.

Same store other operating revenues, adjusted to exclude transactional gains and other items, have decreased $63.2 million for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30, 2017, due primarily to reductions in clinical engineering support provided to external parties and decreased premium revenues.

Same store patient volume increases (decreases) are summarized below.

Twelve Months Ended June 30, 2018 Compared to Twelve Months Ended June 30, 2017

Same Store Patient Volumes	Increase (Decrease)	Increase (Decrease)
	Unaudited	
Adjusted Admissions	(1.5)%	(16,237)
Acute Admissions	(3.4)%	(15,914)
Acute Inpatient Days	(3.0)%	(66,076)
Inpatient ER Visits	(2.5)%	(6,567)
Inpatient Surgeries	(3.9)%	(5,709)
Outpatient ER Visits	(1.2)%	(21,463)
Outpatient Non-ER Visits	(2.8)%	(152,664)
Outpatient Surgeries	(2.6)%	(6,263)
Physician Visits	3.9%	408,537

OPERATING EXPENSES

Increases (decreases) in same store total operating expenses before restructuring, impairment and other losses are summarized below.

Twelve Months Ended June 30, 2018 Compared to Twelve Months Ended June 30, 2017

($ In millions) Same Store Expense	2018	2017	Increase (Decrease)
	Unaudited		
Total labor	$7,016.4	$7,141.6	$(125.2)
Supplies	2,413.8	2,376.8	37.0
Purchased services	1,673.9	1,715.8	(41.9)
Medical professional fees	518.2	441.7	76.5
Interest	312.8	289.0	23.8
Depreciation and amortization	841.6	794.6	47.0
All other	2,156.2	2,149.9	6.3
Total operating expenses	$14,932.9	$14,909.4	$23.5

Same store labor and supply indicators are summarized below.

Twelve Months Ended June 30, 2018 Compared to Twelve Months Ended June 30, 2017

Same Store Labor & Supply	2018	2017
	Unaudited	
Labor % of net patient services revenues	50.2%	52.5%
Labor % of total operating expense	47.0%	48.0%
Supplies % of net patient services revenues	17.3%	17.5%
Supplies % of total operating expense	16.2%	15.9%

Reductions in same store total labor costs and purchased services for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30, 2017, were a result of strategic initiatives to reduce overall expenses across CHI as described in more detail below.

Same store total labor costs decreased $125.2 million for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30, 2017, due to a reduction of FTEs of 2,382 or $226.4 million, offset by an increase in average hourly rates of $101.2 million. CHI continues to address labor productivity within the regions, as well as growth initiatives in certain physician practices where

labor costs have been added in anticipation of future increased patient volumes.

Same store medical professional fees increased $76.5 million, or 17.3%, for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30 2017, largely due to the movement of employed physicians to a professional fee contract model primarily in the Texas region.

Same store supplies as a percentage of net patient services revenues were 17.3% for the fiscal year ended June 30, 2018, and 17.5% for the fiscal year ended June 30, 2017, and included $21.6 million in increased pharmacy supplies expenses and $15.4 million in increased medical surgical utilization supplies expenses.

Same store interest expense increased $23.8 million, or 8.2% for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30, 2017, largely due to increased variable-rate debt interest cost increases as a result of rising market rates. Total debt outstanding decreased $114.1 million during the fiscal year ended June 30, 2018 due to regularly scheduled debt service payments.

Same store depreciation and amortization expenses increased $47.0 million, or 5.9% for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30, 2017, and included $20.1 million in increased expense due to changes in the estimated remaining useful life of certain information technology assets.

REGIONAL OPERATING TRENDS

The Corporation periodically reviews its allocation methodology for corporate support services and may adjust those allocations based on the strategic needs and resource consumption of the regions and CHI overall. These changes in allocation methodologies may increase or decrease a region's operating results from year to year, but have no impact on the consolidated results of CHI.

Regional operations were improved primarily by favorable expense management offsetting reduced patient volumes for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30, 2017. The Pacific Northwest, Colorado, Texas, Nebraska and Kentucky regions represent CHI's five largest operating regions, and for the fiscal year ended June 30, 2018, represented 70.4% of CHI's consolidated operating revenues. Additional information on these regions is discussed below.

Pacific Northwest - the region's operating EBIDA before restructuring, impairment and other losses totaled $292.1 million for the fiscal year ended June 30, 2018 and decreased $77.4 million compared to the fiscal year ended June 30, 2017. Results included $85.7 million in net favorable results primarily from the sale of certain outpatient ambulatory business lines and a $14.9 million gain on sale of interests in various laboratory operations for the fiscal year ended June 30, 2017. Net patient services revenues increased $116.9 million for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30, 2017, and included managed care contract rate increases of $45.8 million, $37.5 million in other contract rate increases and other improvements, favorable shifts in acuity of $20.0 million, and volume increases of $13.6 million. The growth in net patient services revenues exceeded the $83.3 million in increased operating expenses for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30, 2017. The increase in operating expenses was primarily a result of increased compensation, inflation increases, and depreciation increases, slightly offset by continued implementation of expense management and productivity improvements across the region. Depreciation and amortization expenses increased $14.6 million, or 12.4% for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30, 2017, due to facility expansion and renovation activities which has increased capitalized assets and related depreciation.

Total net revenue per adjusted admission increased 6.0% for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30, 2017, while total operating expense per adjusted admission increased 4.8% for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30, 2017. Total labor as a percentage of net patient services revenues decreased to 51.0% for the fiscal year ended June 30, 2018, compared to 51.9% for the fiscal year ended June 30, 2017, due to ongoing labor productivity improvements, representing a favorable expense variance of $24.9 million. Supply expense as a percentage of net patient services revenues declined to 13.5% for the fiscal year

ended June 30, 2018, compared to 13.8% for the fiscal year ended June 30, 2017, which represents a favorable expense variance of $6.4 million due to improved utilization.

Colorado - the region's operating EBIDA before restructuring, impairment and other losses totaled $318.4 million for the fiscal year ended June 30, 2018 and increased $42.5 million compared to the fiscal year ended June 30, 2017. Results included a $10.3 million gain on sale of interests in various laboratory operations for the fiscal year ended June 30, 2017. Net patient services revenues increased $67.3 million for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30, 2017, and included $38.2 million in increased provider fee revenue from the state-based reimbursement programs, $22.5 million in contract rate increases and other improvements, and favorable shifts in acuity of $19.6 million, offset by decreases in volume of $13.0 million. The state-based reimbursement program included increased program expenses of $36.4 million for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30, 2017. Additional state-based reimbursement revenues provided a net revenue benefit of $1.9 million. Operating expenses increased $32.4 million for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30, 2017, and included the $36.4 million expense increase for the state-based reimbursement program, as noted above.

Total net revenue per adjusted admission increased 4.8% for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30, 2017, while total operating expense per adjusted admission increased 3.2% for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30, 2017. Total labor as a percentage of net patient services revenues decreased to 39.5% for the fiscal year ended June 30, 2018, compared to 42.5% for the fiscal year ended June 30, 2017, representing a favorable expense variance of $68.6 million. Supply expense as a percentage of net patient services revenues declined to 14.9% for the fiscal year ended June 30, 2018, compared to 15.0% for the fiscal year ended June 30, 2017, which represents a favorable expense variance of $3.7 million due to improved utilization.

Texas - the region's operating EBIDA before restructuring, impairment and other losses totaled $84.3 million for the fiscal year ended June 30, 2018 and increased $20.0 million compared to the fiscal year ended June 30, 2017. Results included $24.4 million in gains on real estate sales for the fiscal year ended June 30, 2017.

Operations in the Texas region were impacted in late August 2017 by Hurricane Harvey, which caused the temporary closure and evacuation of two facilities, resulting in decreased patient volumes due to rescheduling of procedures and visits, and additional expenses. The total impact to operations was estimated at approximately $25.8 million. In December 2017, the Texas region recognized $14.6 million of insurance recoveries which were primarily funded by FIIL.

Net patient services revenues increased $68.1 million for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30, 2017, and included $39.3 million in managed care contract rate increases, $31.8 million in other contract rate increases and other improvements, volume increases of $14.7 million, and $9.8 million in favorable service mix shifts, offset by $27.5 million in decreased provider fee revenue from the state-based reimbursement programs. The change in the state-based reimbursement programs had a decrease in programs expenses of $4.9 million for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30, 2017, for a net state-based reimbursement programs impact of $22.6 million in reduced operating EBIDA before restructuring, impairment and other losses. Total operating expenses increased $38.0 million for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30, 2017.

Total net revenue per adjusted admission increased 5.2% for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30, 2017, while total operating expense per adjusted admission increased 3.5% for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30, 2017. Total labor as a percentage of net patient services revenues decreased to 43.2% for the fiscal year ended June 30, 2018, compared to 48.4% for the fiscal year ended June 30, 2017, representing a favorable expense variance of

$111.0 million. However, medical professional fees expense increased $63.8 million and purchased services expense increased $47.3 million for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30, 2017, due to a shift in classification of certain services and physician compensation arrangements. Supply expense as a percentage of net patient services revenues increased to 20.0% for the fiscal year ended June 30, 2018, compared to 19.4% for the fiscal year ended June 30, 2017, which represents an unfavorable expense variance of $13.2 million. Management is continuing to implement strategies to improve labor productivity, supply chain, and overall expense savings in the Texas region.

Nebraska - the region's operating EBIDA before restructuring, impairment and other losses totaled $238.3 million for the fiscal year ended June 30, 2018 and increased $131.6 million compared to the fiscal year ended June 30, 2017. Results included $13.6 million in favorable and $28.0 million in unfavorable net patient services revenues adjustments for the fiscal year ended June 30, 2018, and 2017, respectively. Net patient services revenues increased $50.3 million for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30, 2017, and included a favorable $53.3 million in accounts receivable reserve changes and bad debt reconciliation adjustments between years, $26.3 million in other contract rate increases and other improvements, and managed care contract rate increases of $20.1 million, offset by decreases in volume of $49.4 million.

Total net revenue per adjusted admission increased 4.9% for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30, 2017, while total operating expense per adjusted admission decreased 1.5% for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30, 2017. Total operating expenses decreased $75.1 million for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30, 2017, due to continued implementation of expense management and productivity improvements. Total labor as a percentage of net patient services revenues decreased to 53.9% for the fiscal year ended June 30, 2018, compared to 56.5% for the fiscal year ended June 30, 2017, representing a favorable expense variance of $50.5 million. Supply expense as a percentage of net patient services revenues decreased to 15.4% for the fiscal year ended June 30, 2018, compared to 16.8% for the fiscal year ended June 30, 2017, representing a favorable expense variance of $26.7 million.

Kentucky - the region's operating EBIDA before restructuring, impairment and other losses (excluding discontinued operations) totaled $89.1 million for the fiscal year ended June 30, 2018 and increased $20.3 million compared to the fiscal year ended June 30, 2017. Net patient services revenues decreased $34.8 million for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30, 2017, and included volume decreases of $72.3 million, which is partly due to the home health business moving to CHI Health at Home, a division within CHI, and $8.0 million in decreases due to favorable managed care settlements in fiscal year 2017 that did not recur, offset by $34.3 million in contract rate increases and other improvements and favorable shifts in acuity of $11.2 million. Operating expenses decreased $79.7 million for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30, 2017, due to continued implementation of expense management and labor productivity improvements across the region.

Total net revenue per adjusted admission increased 1.4% for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30, 2017, while total operating expense per adjusted admission decreased 2.6%. Total labor as a percentage of net patient services revenues decreased to 47.2% for the fiscal year ended June 30, 2018, compared to 47.9% for the fiscal year ended June 30, 2017, representing a favorable expense variance of $6.2 million. Supply expense as a percentage of net patient services revenues increased to 19.3% for the fiscal year ended June 30, 2018, compared to 18.8% for the fiscal year ended June 30, 2017, representing a favorable expense variance of $5.6 million.

CHI Corporate services and other business lines - operating EBIDA before restructuring, impairment and other losses totaled $148.5 million, and improved $106.7 million for the fiscal year ended June 30, 2018, compared to the fiscal year ended June 30, 2017. Margin improvements include focused cost reductions in all support services and include $59.7 million related

to information technology services, $29.1 million in reductions for National support services, and $17.9 million related to self-insurance welfare benefit programs. Changes in support services activities relate to a variety of factors and include strategic transfers of support activities from the regions and other service lines to corporate services to build corporate support functions, and new implementations of system-wide services. Support services allocations to the regions consider the strategic needs and resource consumption of the regions and CHI overall. Expense decreases have occurred within various support services concentrated within Information Technology, Clinical Engineering and Onshore Risk and Insurance.

Restructuring, Impairment and Other Losses

($ in thousands)	Twelve Months Ended June 30, 2018	2017
	Unaudited	
Changes in business operations	$ 40,043	$ 206,297
Severance costs	33,810	68,860
Impairment charges	14,231	48,356
Pension settlement costs	53,199	39,678
Total restructuring, impairment and other losses	$ 141,283	$ 363,191
Non-cash expenses related to restructuring, impairment and other losses	$ 67,443	$ 147,401

Restructuring, impairment, and other losses include charges relating to changes in business operations, severance costs, EPIC go-live support costs, goodwill impairments, acquisition-related costs, and pension settlement activity. Changes in business operations include costs incurred periodically to implement reorganization efforts within specific operations, to align CHI's operations in the most strategic and cost-effective manner. The non-cash portion of total restructuring, impairment and other losses includes impairment charges, pension settlement costs, and project cost abandonment charges included in changes in business operations.

Nonoperating Results

($ in thousands)	Twelve Months Ended June 30, 2018	2017
	Unaudited	
Investment gains, net	$ 442,496	$ 629,216
Gains (losses) on early extinguishment of debt	208	(19,586)
Realized and unrealized gains on interest rate swaps	52,123	92,698
Other nonoperating gains	3,987	2,007
Total nonoperating gains	$ 498,814	$ 704,335

3. SUMMARY OF CHI BALANCE SHEETS AS OF JUNE 30, 2018 AND 2017

Total assets were $20.6 billion and $21.9 billion at June 30, 2018 and 2017, respectively, representing a decrease of 6.1%, or $1.3 billion, during the fiscal year ended June 30, 2018. The decrease was primarily attributable to a $992.1 million decrease in assets of discontinued operations, due to the deconsolidation of UMC on July 1, 2017 and the impairment of JHSMH's discontinued operation assets on December 31, 2017 and on June 30, 2018, as well as a decrease of $537.2 million in cash and unrestricted investments during the fiscal year ended June 30, 2018.

Total cash and equivalents, and unrestricted investments were $5.8 billion and $6.4 billion at June 30, 2018 and 2017, respectively, representing a decrease of 8.5%, or $537.2 million during the fiscal year ended June 30, 2018. Decreases included $90.5 million due to the deconsolidation of the Dayton assets in exchange for a 22% equity method investment in Premier. For the fiscal year ended June 30, 2018, CHI spent a net $796.1 million in investing cash flow activities, including $759.7 million of on-going capital investment activity, which includes IT infrastructure investments, as well as new hospital construction and facility renovations across CHI. Financing cash flow decreases for the fiscal year ended June 30, 2018, totaled $238.8 million and include net debt and interest payments, net swap collateral receipts, and $150.0 million for the purchase of the remaining non-controlling interest in KentuckyOne. Working capital changes and cash flows from operations, including investments and assets limited to use, increased $738.2 million for the fiscal year ended June 30, 2018.

Days of cash on hand decreased to 149 days at June 30, 2018, from 161 at June 30, 2017. For purposes of the days of cash on hand calculation, one day of operating expenses represented $39.1 million and $39.6 million at June 30, 2018, and 2017, respectively.

Net patient accounts receivable were $2.1 billion at both June 30, 2018 and 2017, representing a slight increase of 2.8%, or $57.5 million, during the fiscal year ended June 30, 2018. Total liabilities were $13.5 billion and $14.2 billion at June 30, 2018 and 2017, respectively, representing a decrease of 5.2%, or $741.5 million, during the fiscal year ended June 30, 2018, including a $256.6 million decrease in pension liability balances, a $193.0 million decrease in liabilities of discontinued operations, primarily as a result of the deconsolidation of UMC on July 1, 2017, a $114.1 million decrease in outstanding debt balance, and a $98.8 million decrease in accounts payable and accrued expenses as a result of working capital changes.

The unfunded pension benefit obligation, reported as long-term liabilities, was $854.4 million and $1.1 billion at June 30, 2018 and 2017, respectively, representing a $256.6 million decrease. The pension benefit obligation decreased $218.1 million during the fiscal year ended June 30, 2018, due to favorable actuarial assumption changes at June 30, 2018, including a decrease of $230.0 million as a result of the increase in the discount rate assumption. Pension plan assets increased $38.4 million during the fiscal year ended June 30, 2018, due to $272.5 million in investment income and $108.6 million in plan contributions, offset by $340.8 million of plan distributions to participants.

Total debt was $8.5 billion and $8.6 billion at June 30, 2018, and 2017, respectively, and includes a decrease of $114.1 million due to regularly scheduled debt service payments.

The debt-to-capitalization ratio increased to 55.5% at June 30, 2018, from 53.8% at June 30, 2017, primarily due to a decrease in unrestricted net assets. Total unrestricted net assets decreased 7.9%, or $583.3 million during the fiscal year ended June 30, 2018, primarily due to a $319.2 million loss on the deconsolidation of UMC, a $377.5 million impairment of JHSMH's discontinued operation assets, a $150.0 million decrease from the purchase of the remaining non-controlling interest in KentuckyOne, and a $97.1 million net loss from discontinued operations, offset by $222.1 million in excess of revenues over expenses and a $143.6 million favorable change in pension funded status.

4. CERTAIN CONTRACTUAL OBLIGATIONS

CAPITAL OBLIGATION DOCUMENT

The obligations of the Corporation to pay amounts due on its commercial paper notes, revenue bonds, guarantees and certain swap agreements are evidenced by Obligations issued under the Capital Obligation Document ("COD"). Obligations also evidence the Corporation's obligations to banks that provide funds for the purchase of indebtedness tendered for purchase or subject to mandatory tender for purchase and not remarketed under the Corporation's self-liquidity program, funded loans and for general purpose revolving lines of credit.

At June 30, 2018, the Corporation's outstanding indebtedness evidenced by Obligations issued under the COD totaled $7.93 billion. Payment obligations under the COD are limited to the Obligated Group (defined in the COD), which only includes the Corporation. Certain covenants under the COD are tested based on the combination of the Obligated Group and Participants. However, holders of Obligations have no recourse to Participants or their property for payment thereof.

INDEBTEDNESS

($ in millions)	June 30, 2018	2017
Capital Obligation Debt		
Fixed Rate Bonds[1]	$4,575	$ 4,894
Variable Rate Bonds[2]	508	508
Long Term Rate Bonds[3]	142	142
Direct Purchase Bonds[4]	1,578	1,002
Commercial Paper Notes	881	815
Short term bank loans and lines of credit	250	584
Total Capital Obligation Debt	**$7,934**	**$ 7,945**
Non-Capital Obligation Debt		
Other MBO Debt[5]	$385	$ 458
Capital Leases	113	106
Note Payable issued to Episcopal Health Foundation	99	134
Total Non-Capital Obligation Debt	**597**	**$ 699**
Total CHI Debt	**$8,531**	**$ 8,644**

[1]Excludes unamortized original issue premium, discount and issuance costs.
[2] Includes bonds that bear interest at variable rates (currently determined weekly) and are subject to optional tender for purchase by their holders, FRNs that bear interest at variable rates (currently determined weekly and monthly), for a specified period and are subject to mandatory tender as set forth below and direct purchase debt of affiliates that is placed directly with holders, bears interest at variable rates determined monthly based upon a percentage of LIBOR or SIFMA plus a spread, and is subject to mandatory tender on certain dates.
[3] Long-term rate bonds bear interest at a fixed rate for a specified period and are subject to mandatory tender at the end of such period as set forth below.
[4] Direct purchase debt of the Corporation is placed directly with holders, bears interest at variable rates determined monthly based upon a percentage of LIBOR or SIFMA plus a spread, and is subject to mandatory tender on certain dates as set forth below.
[5] Other debt is comprised mostly of $187.0 million of CHI St. Luke's affiliate debt, $94.4 million of Centura affiliate debt and $50.9 million of SFH affiliate debt.

The required principal payments on the total CHI long-term debt during fiscal year 2019 is approximately $697.7million.

As of the date of this report, the Corporation had one revolving line of credit with PNC Bank in the amount of $250 million that is fully drawn and matures on July 3, 2019.

A. Direct Purchase Debt

The Corporation's direct purchase debt is subject to mandatory tender on the dates set forth in the following table. Prior to the mandatory tender of direct purchase debt, management expects that it would analyze the then current market conditions and availability and relative cost of refinancing or restructuring alternatives which could include without limitation, conversion to another interest mode, refinancing or repayment.

Series ($ in millions)	Par Outstanding June 30, 2018	Mandatory Tender Date
Taxable 2016[1]	$200.0	9/30/2018
Providence Series 2009A[2]	6.5	10/1/2018
Providence Series 2009B[2]	5.6	10/1/2018
Providence Series 2009C[2]	4.0	10/1/2018
Taxable 2017A[3]	250.0	10/29/2018
Colorado 2011C[4]	117.0	11/10/2018
Colorado 2017B	333.7	12/19/2018
Washington 2008A[4]	118.9	1/29/2019
Colorado 2004B6[4]	54.2	9/15/2020
Taxable 2013E	125.0	12/18/2020
Taxable 2013F	75.0	12/18/2020
Colorado 2015-1	35.0	8/1/2021
Colorado 2015-2	63.5	8/1/2021
Colorado 2013C	100.0	12/18/2023
Colorado 2015A	17.1	8/1/2024
Colorado 2015B	27.3	8/1/2024
Washington 2015A	45.4	8/1/2024

[1] The 2016 taxable bonds were repaid in full on August 30, 2018. The Corporation issued the Colorado Health Facilities Authority Taxable Revenue Bonds Series 2018 B on August 30, 2018 in the amount of $200 million with a mandatory tender date of August 30, 2019.
[2] The bondholder of the Providence 2009 Series A, B and C has given notice that they will not elect to tender the bonds on October 1, 2018. The new mandatory tender date is October 1, 2019.
[3] The Taxable 2017 A bonds mandatory tender date was extended to July 1, 2021.
[4] Includes a "term out" provision that varies among agreements, which permits repayment after the mandatory tender date absent any defaults or events of default.

The Corporation's direct purchase agreements are publicly available, and can be accessed through the Digital Assurance Certification LLC website ("DAC") at www.dacbond.com and the Municipal Securities Rulemaking Board ("MSRB") through the Electronic Municipal Market Access ("EMMA") website of the MSRB, which can be found at http://emma.msrb.org.

B. Long – Term Rate Bonds

The Corporation's long-term rate bonds are subject to mandatory tender on the dates set forth below. Prior to the mandatory tender of long-term rate bonds, management expects that it would analyze the then current market conditions and availability and relative cost of refinancing or restructuring alternatives, which could include without limitation, conversion to another interest mode, refinancing or repayment.

Series ($ in millions)	Par Outstanding June 30, 2018	Mandatory Tender Date
CO 2009B-3	$40.0	11/6/2019
KY 2009B	60.0	11/10/2021
CO 2008D-3	41.9	11/12/2021
Total Long-Term Rate Bonds	**$141.9**	

C. Floating Rate Notes ("FRNs")

The Corporation's FRNs are subject to mandatory tender on the dates set forth below. Prior to the mandatory tender of the FRNs, management expects that it would analyze the then current market conditions and availability and relative cost of refinancing or restructuring alternatives, which could include without limitation, conversion to another interest mode, refinancing or repayment.

Series ($ in millions)	Par Outstanding June 30, 2018	Mandatory Tender Date
KY 2011B-1	$ 52.7	1/31/2020
KY 2011B-2	52.7	1/31/2020
CO 2008C-2	26.5	11/12/2020
CO 2008C-4	26.5	11/122020
WA 2013B-1	100.0	12/31/2020
WA 2013B-2	100.0	12/31/2024
KY 2011B-3	52.7	1/31/2025
Total FRNs	**$411.1**	

D. Variable Rate Bonds

The Corporation's variable rate demand bonds are subject to optional and mandatory tender. As of June 30, 2018, variable rate demand bonds are outstanding in the amount of $96.7 million, supported by the Corporation's self-liquidity, not by a dedicated liquidity or credit facility. See *Part VII: 5. Liquidity and Capital Resources - Liquidity Arrangements*.

E. Taxable Commercial Paper

The Corporation's commercial paper note program permits the issuance of up to $881 million in aggregate principal amount outstanding, with maturities limited to 270-day periods. The Corporation has directed the commercial paper dealers to tranche the commercial paper maturities so that no greater than approximately one-third of the outstanding balance matures in any one month, and no more than $100 million matures per dealer within any five business-day period while the outstanding balance of the commercial paper is greater than $500 million. The Corporation has, from time to time, directed its dealers to deviate from such directions, and may do so again in the future. As of June 30, 2018, $881 million of commercial paper notes were outstanding. The commercial paper notes are supported by the Corporation's self-liquidity, and not supported by a dedicated liquidity or credit facility. See *Part VII: 5. Liquidity and Capital Resources - Liquidity Arrangements.*

F. Swap Agreements

The Corporation or its affiliates are currently party to 35 swap transactions that had an aggregate notional amount of approximately $1.6 billion at June 30, 2018. The 35 transactions have varying termination dates ranging from 2018 to 2047. The swap agreements require the Corporation (or with respect to certain swap agreements, affiliates of the corporation) to provide collateral if its respective liability, determined on a mark-to-market basis, exceeds a specified threshold that varies based upon the rating on the Corporation's long-term indebtedness. The swap agreements of Memorial East Texas and Centura Health do not require collateral postings. The fair value of the swaps is estimated based on the present value sum of anticipated future net cash settlements until the swaps' maturities. Cash collateral balances are netted against the fair value of the swaps, and the net amount is reflected in other liabilities in the accompanying consolidated balance sheets. At June 30, 2018, the net swap liability reflected in other liabilities was $33.6 million, net of swap collateral posted of $174.9 million. The swap agreements, excluding the Centura Health swap, are secured by Obligations issued under the COD. *(See Note 10 in the Consolidated Financial Statements (Audited) as of June 30, 2018 and 2017.)*

Obligated Party ($ in millions)	Type	Outstanding Notional June 30, 2018	Termination Date
CHI[1]	Total Return	$ 77.7	8/9/2018 -1/16/2020
CHI	Fixed Payer	150.9	5/1/2025
CHI	Fixed Payer	217.8	3/1/2032
CHI	Fixed Payer	97.9	9/1/2036
CHI	Fixed Payer	127.3	9/1/ 2036
CHI	Fixed Payer	19.6	9/1/2036
CHI	Fixed Payer	99.0	12/1/2036
CHI	Fixed Payer	148.5	12/1/2036
CHI St. Luke's	Fixed Payer	119.0	2/18/2031
CHI St. Luke's	Fixed Payer	92.5	2/15/2032
CHI St. Luke's	Fixed Payer	100.0	2/15/2047
CHI St. Luke's	Fixed Payer	100.0	2/15/2047
Centura Health[2]	Fixed Payer	14.6	5/20/2024
Madonna Manor	Total Return	27.0	8/15/2020
Memorial East Texas	Fixed Payer	24.0	2/15/2035
Memorial East Texas	Fixed Payer	16.8	2/15/2028
St. Joseph Regional Health[3]	Total Return	49.8	8/15/2020
St. Joseph Regional Health	Fixed Payer	45.2	1/1/2028
St. Joseph Regional Health	Basis	30.0	3/1/2028
Total Notional Amount		**$ 1,557.6**	

[1] Represents 14 Total Return Swaps.
[2] Not secured by CHI COD obligations.
[3] Represents 4 Total Return Swaps.

5. LIQUIDITY AND CAPITAL RESOURCES

Cash Equivalents and Internally Designated Investments

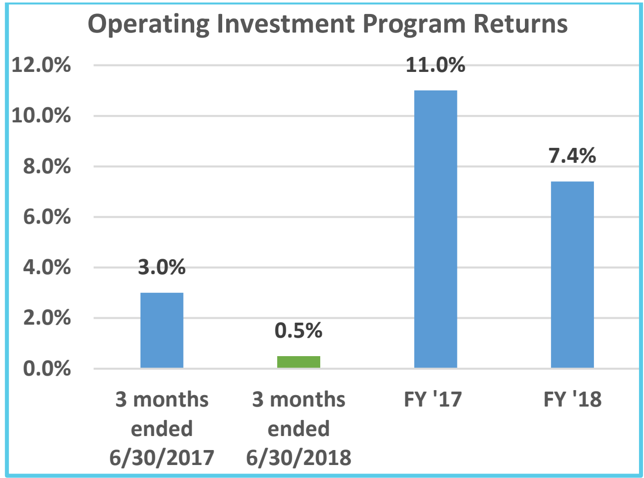
CHI holds highly liquid investments to enhance its ability to satisfy liquidity needs. Asset allocations are reviewed monthly and compared to investment allocation targets included within CHI's investment policy. At June 30, 2018 and 2017, CHI had cash and equivalents and internally designated investments (including net unrealized gains and losses) as described in the table below.

($ in thousands)	June 30, 2018	June 30, 2017
Cash and equivalents	$ 510,456	$ 810,235
Internally designated investments	5,308,868	5,546,290
Total	**$ 5,819,324**	**$ 6,356,525**

CHI maintains an Operating Investment Program (the "Program") administered by the Corporation. The Program is structured as a limited partnership with the Corporation as the managing general partner.

The Program contracts with investment advisers to manage the investments within the Program. Substantially all CHI long-term investments are held in the Program. The Corporation requires all Participants to invest in the Program. The Program consists of equity securities, fixed-income securities and alternative investments (e.g., private equity, hedge funds and real estate interests). The asset allocation is established by the Finance Committee of the Board of Stewardship Trustees. At June 30, 2018, the asset allocation for the Program's Long-Term Pool was 45% equity securities, 30% fixed-income securities, 25% alternative investments, and 0% cash and equivalents. Alternative investments within the Program have limited liquidity. As of June 30, 2018, illiquid investments not available for redemption totaled $395.0 million, and investments available for redemption within 180 days at the request of the Program totaled $858.5 million. The asset allocation for the Program's Intermediate Pool was 100% fixed-income securities. As of June 30, 2018, 92.0% of the Program's assets were invested in the Long-Term Pool, with 8.0% of assets invested in the Intermediate

Pool. The Program's return for the three months ended June 30, 2018 and 2017 and for the fiscal years ended June 30, 2018 and 2017 are listed in the chart below.



LIQUIDITY ARRANGEMENTS

The Corporation maintains several liquidity facilities that are dedicated to funding optional or mandatory tenders of its variable rate debt and paying the maturing principal of the commercial paper notes in the event remarketing proceeds are unavailable for such purpose. At June 30, 2018, no amounts were drawn on these lines. The Corporation's dedicated self-liquidity lines are set forth below and can be found at http://emma.msrb.org.

CHI Dedicated Self-Liquidity Lines – June 30, 2018

Bank *$ in millions*	Committed Amount	Expiration
MUFG Union Bank[1]	75.0	9/27/2019
J.P. Morgan[1]	50.0	9/30/2019
Bank of New York Mellon	50.0	12/14/2018
Northern Trust	65.0	6/28/2019
PNC Bank	125.0	8/23/2019
Total Self-Liquidity Lines	**$ 365.0**	

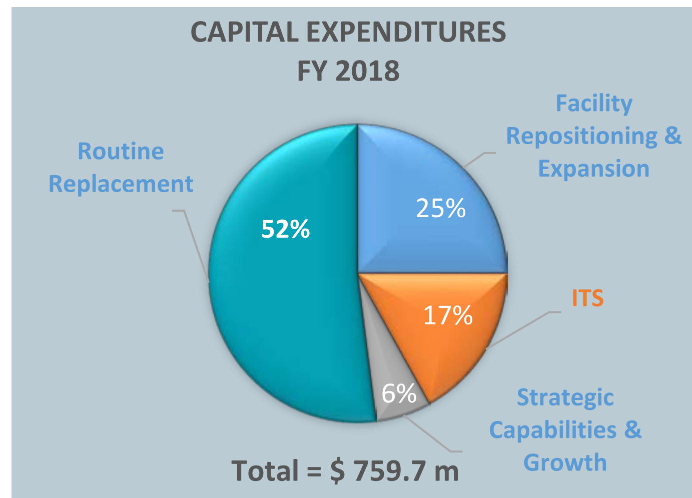
[1] Subsequent to June 30, 2018 the dedicated self-liquidity line was extended with the maturity date noted above.

6. LIQUIDITY REPORT

CHI posts a liquidity report monthly, which can be found at www.catholichealthinitiatives.org and http://emma.msrb.org.

7. CAPITAL EXPENDITURES

The chart below reflects capital allocations for fiscal year 2018 to information technology ("ITS"), strategic capabilities and growth, facility repositioning and expansion, as well as routine replacement of capital assets.



8. COVENANT COMPLIANCE

The following table presents the Historical Long-Term Debt Service Coverage Ratio for fiscalyars ended June 30, 2018 and 2017.

CHI Historical Long-Term Debt Service Coverage

($ in thousands)	June 30, 2018	June 30, 2017
Income available for debt service		
Total Revenues (included nonoperating gains)	$ 15,480,901	$ 15,747,005
Total Operating Expenses (includes restructuring)	15,258,800	15,636,112
Excess of Revenues over Expenses	222,101	110,893
Add: Interest on Long-Term Indebtedness	256,953	264,319
Add: Depreciation and Amortization	856,188	824,386
Add: Non-Cash Restructuring, Impairment and Other Losses	14,244	107,723
Add: Losses (Gains) on Defeasance of Bonds and Escrow	(208)	19,586
Add: Net periodic pension expense (income)	(4,367)	(9,348)
Add: Unrealized Losses (Gains) on Interest Rate Swaps	(79,596)	(127,866)
Add: Net Investment Unrealized Losses (Gains)	(11,731)	(152,085)
Total Adjustments to Excess (Deficiency) of Revenues Over Expenses	1,031,483	926,715
Total income available for debt service	**$ 1,253,584**	**$ 1,037,608**
Debt service requirements on Long Term Indebtedness:		
Total CHI Principal Payments	116,619	133,650
Total CHI Interest Payments	265,470	277,299
Total Debt Service Requirements on Long Term Indebtedness:	**$ 382,089**	**$ 410,949**
Historical Long-Term Debt Service Coverage Ratio	**3.3x**	**2.5x**

9. PENSION AND RETIREMENT PLAN OBLIGATIONS

CHI Penson Plan

CHI and its direct affiliates maintain a variety of noncontributory, defined benefit retirement plans (Retirement Plans) for their employees. Certain of these plans were frozen in previous fiscal years, and benefits earned by employees through that time period remain in the Retirement Plans, where employees continue to receive interest credits and vesting credits, if applicable. Vesting occurs over a five-year period. Benefits in the Retirement Plans are based on compensation, retirement age, and years of service. Substantially all the Retirement Plans are qualified as church plans and are exempt from certain provisions of both the Employee Retirement Income Security Act of 1974 and Pension Benefit Guaranty Corporation premiums and coverage. Funding requirements are determined through consultation with independent actuaries.

CHI recognizes the funded status (the difference between the fair value of plan assets and the projected benefit obligations) of its Plans in the consolidated balance sheets, with a corresponding adjustment to net assets. Actuarial gains and losses that arise and are not recognized as net periodic pension cost in the same periods are recognized as a component of changes in

net assets. CHI recognized an unfunded status for the Plans of $854.4 million and $1.1 billion at the June 30, 2018 and 2017 measurement dates, respectively. The fair value of the Plan assets was $4.1 billion at both June 30, 2018 and 2017.

CHI recognized net periodic pension expense (income) of $39.5 million and $28.1 million for the three months ended June 30, 2018 and 2017, respectively, and $(4.4) million and $(9.3) million for the fiscal years ended June 30, 2018 and 2017, respectively. Pension income is the result of the decline in the service cost of the frozen CHI plan and lower discount assumptions in the current fiscal year. The service cost, interest cost, expected return on the Plans' assets, actuarial losses, and amortization of prior service benefit components of net periodic pension expense (income) are recognized in the consolidated statements of operations within employee benefits expense. The curtailment and settlement components of net periodic pension expense (income) are recognized in the consolidated statements of operations within restructuring, impairment and other losses.

The expected return on the Plans' assets for determining pension cost was 5.5-7.2% for both fiscal years ended June 30, 2018 and 2017. The assumption for the expected return on the Plans' assets is based on historical returns and adherence to the asset allocations set forth in the Plans' investment policies.

Certain of the Plans' investments are held in the CHI Master Trust, which was established for the investment of assets of the Plans. The CHI Master Trust investment portfolio is designed to preserve principal and obtain competitive investment returns and long-term investment growth, consistent with actuarial assumptions, while minimizing unnecessary investment risk. Diversification is achieved by allocating assets to various asset classes and investment styles and by retaining multiple investment managers with complementary philosophies, styles and approaches. Although the objective of the CHI Master Trust is to maintain asset allocations close to target, temporary periods may exist where allocations are outside of the expected range due to market conditions. The use of leverage is prohibited except as specifically directed in the alternative investment allocation. The portfolio is managed on a basis consistent with the CHI social responsibility guidelines.

A summary of the CHI Master Trust asset allocations by asset class at the measurement dates of June 30, 2018 and 2017 are as follows:

	June 30,	
	2018	2017
Equity securities	47%	48%
Fixed-income securities	34%	33%
Alternative investments	19%	19%

CHI 401(k) Retirement Savings Plan

CHI sponsors the CHI 401(k) Retirement Savings Plan (401(k) Savings Plan) for its employees whereby CHI matches 100.0% of the first 1.0% of eligible pay an employee contributes to the plan, and 50.0% of the next 5.0% of eligible pay contributed to the plan, for a maximum employer matching rate of 3.5% of eligible pay. On an annual basis and regardless of whether an employee participates in the 401(k) Savings Plan, CHI will also contribute 2.5% of eligible pay to an employee's 401(k) Savings Plan account. This contribution is made if an employee reaches 1,000 hours in the first year of employment, or every calendar year thereafter, and is employed on the last day of the calendar year. An employee is fully vested in the plan for employer contributions after three years of service. CHI recorded 401(k) Savings Plan expense of $54.0 million and $55.7 million for the three months ended June 30, 2018 and 2017, respectively, and $218.8 million and $224.2 million for the fiscal years ended June 30, 2018 and 2017, respectively.

10. COMMUNITY BENEFIT

In accordance with its mission and values, CHI commits substantial resources to sponsor a broad range of services to the poor as well as the broader community. Community benefit to the poor includes the cost of providing services to persons who cannot afford health care due to inadequate resources and/or who are uninsured or underinsured. This type of community benefit includes the costs of traditional charity care; unpaid costs of care provided to beneficiaries of Medicaid and other indigent public programs; services such as free clinics and meal programs for which a patient is not billed or for which a nominal fee has been assessed; and cash and in-kind donations of equipment, supplies or staff time volunteered on behalf of the

community. Community benefit provided to the broader community includes the costs of providing services to other populations that may not qualify as poor but may need special services and support. This type of community benefit includes the costs of services such as health promotion, education, clinics and screenings. In addition, it includes all services that are not billed or can be operated only on a deficit basis; unpaid portions of training health professionals such as medical residents, nursing students and students in allied health professions; and the unpaid portions of testing medical equipment and controlled studies of therapeutic protocols.

The cost to CHI of community benefit provided to the poor and the broader community (excluding unpaid Medicare costs) totaled $1.1 billion and $1.2 million in the fiscal years ended June 30, 2018 and 2017, respectively.

11. LONG - TERM BOND RATINGS

The Corporation's fixed rate unenhanced debt is rated BBB+ (positive outlook) by Standard & Poor's Rating Service, Baa1 (stable outlook) by Moody's Investors Service, Inc., and BBB+ (stable outlook) by Fitch Ratings.

12. EMPLOYEES/PROFESSIONAL STAFF

At June 30, 2018, CHI employed over 3,900 providers (including advanced practice clinicians and physicians). At June 30, 2018, CHI employed 91,089 employees. Salary levels and benefit packages for CHI employees are market competitive. 11.4% of CHI's employees are represented by collective bargaining units.

13. ACCREDITATIONS AND LICENSES

CHI's hospital facilities, skilled nursing facilities and long-term care facilities have the necessary licenses to operate their facilities and necessary certifications and licenses for Medicare and Medicaid reimbursement.

14. CONFLICTS OF INTEREST

The Corporation maintains policies that require internal reporting of outside financial and fiduciary activities to protect its interests in circumstances that may result in a conflict between the personal interests of its employees and Trustees and those of CHI. Those policies put in place a general obligation for all employees, employed and non-employed researchers, and trustees to report potential conflicts of interest. In addition, on an annual basis, CHI requires all managers and above, employed medical staff members, researchers and trustees to complete a conflict of interest disclosure. A process is in place to review any potential conflicts of interest disclosed through this annual disclosure process.

PART VIII: GOVERNANCE

CATHOLIC HEALTH INITIATIVES

Board of Stewardship Trustees. The Corporation's Bylaws provide for the governance of the Corporation by a Board of Stewardship Trustees of at least twelve and no more than 21 appointed Trustees, one of which is an *ex officio* Trustee with voting powers. All Trustees serve regular staggered terms of three years. The Board of Stewardship Trustees has the power and the authority to supervise, control, direct and manage the property, affairs, and activities of the Corporation, to determine the policies of the Corporation, to do or cause to be done any and all things for and on behalf of the Corporation, to exercise or cause to be exercised any or all of its powers, privileges, or franchises, and to seek the effectuation of CHI's objectives and purposes.

There are currently six committees of the Board of Stewardship Trustees: the Executive Committee, the Sponsorship and Governance Committee, the Finance Committee, the Human Resources Committee, the Quality and Safety Committee and the Audit and Compliance Committee.

The Board of Stewardship Trustees currently consists of 11 elected Trustees plus the *ex officio* Trustee and meets in person five times a year. The Chief Executive Officer of the Corporation serves as the *ex officio* Trustee and is a voting *ex officio* Trustee. The table below lists the current Trustees, their professional affiliations and the expiration of their terms in office.

Name	Board of Stewardship Trustees Professional Affiliation	Term Expires June 30*
Margaret Ormond, OP	President, Dominican Academy	Extended
Gary Yates, MD	Partner, Strategic Consulting Press Ganey Associates, Inc	Extended
Betsy (Ruth) Goodwin, OSF	Director of Sponsorship Sisters of St. Francis of Philadelphia	Extended
Christopher Lowney, Chairperson	Public Speaker/Author	Extended
James P. Hamill	Retired President & Chief Executive Officer Healthcare Administration	Extended
Antoinette Hardy-Waller, RN, BSN, MJ	CEO The Leverage Network Inc.	Extended
Geraldine "Polly" Bednash, PhD, RN, FAAN	Visiting Professor -University of Vermont College of Nursing and Health Science Adjunct Faculty - Australian Catholic University	2019
Barbara Hagedorn, SC	Volunteer Good Samaritan Free Health Center	2019
Lillian Murphy, RSM	Retired Chief Executive Officer Mercy Housing	2019
Challis Lowe	Retired Chief Human Resources Officer	2019
Kevin E. Lofton, FACHE *Ex-officio* member of the Board	Chief Executive Officer Catholic Health Initiatives	N/A

** Board Members will remain in place until a successor is appointed.*

Participating Congregations. As of June 30, 2018, there are 13 Participating Congregations and one Partnering Congregation of CHI. CHI honors the traditions and services established by the foundresses of these congregations and continued by their participation. The Participating Congregations are: Benedictine Sisters of Mother of God Monastery, Watertown, South Dakota; Congregation of the Dominican Sisters of St. Catherine of Siena, Saratoga, CA; Franciscan Sisters of Little Falls, Minnesota; Dominican Sisters of Peace, Columbus, Ohio; Sisters of Charity of Cincinnati, Ohio; Sisters of Mercy, West Midwest Community, Omaha, Nebraska; Sisters of St. Francis of Philadelphia, Pennsylvania; Sisters of Presentation of the Blessed Virgin Mary of Fargo, North Dakota; The Congregation of the Sisters of Charity of Nazareth, Kentucky; Sisters of St. Francis of the Immaculate Heart of Mary of Hankinson, North Dakota; Sisters of the Holy Family of Nazareth, Des Plaines, Illinois; Sisters of St. Francis of Colorado Springs, Colorado; and Sisters of St. Francis of Sylvania, Ohio. The Partnering Congregation of CHI is the Benedictine Sisters of Annunciation Monastery, Bismarck, North Dakota. All rights of the Participating Congregations as stated in the Corporation bylaws are exercised through a representative appointed by each Participating Congregation. Such rights include (1) approving any substantial change in the mission or philosophical direction of CHI; (2) approving amendments to the Corporation's articles of incorporation or bylaws affecting any provision governing the qualification, rights or responsibilities of the Participating Congregations; (3) selecting and removing without cause a person to represent the Participating Congregation in exercising the rights and duties as described in the Corporation's bylaws; (4) participating in the distribution of assets upon the dissolution of the Corporation, in accordance with the Corporation's Bylaws; (5) participating in organizational advocacy efforts; (6) encouraging members of the Participating Congregations to participate in the ministries sponsored by the Corporation; and (7) participating through their representatives in meetings held at least annually.

GOVERNANCE OF PARTICIPANTS

Governance of Participants. Each Participant is governed by a Board of Directors, subject to the powers

reserved to its corporate member. The corporate member or sole shareholder of each of the Participants (other than Centura Health and certain Participants that are parties to JOAs, as described immediately below) is the Corporation or a local "parent organization," the sole corporate member or sole shareholder of which is the Corporation. The Corporation as sole corporate member has the right to appoint and remove Participant board members, except as otherwise described herein.

Certain Relationship and Control Mechanisms within the Corporation. The Corporation has the right, directly or indirectly, to appoint and remove a majority of the Board of Directors of each Participant, except for certain Participants affiliated with certain JOAs. In addition, the bylaws of substantially all non-profit Participants that own and operate a substantial portion of the property of CHI and constitute a substantial portion of the revenues of CHI permit the Corporation to require such Participants to transfer assets to the Corporation to the extent necessary to accomplish CHI's goals and objectives. The bylaws of such Participants also permit the Corporation to provide for the payment of all indebtedness of the Corporation in furtherance of CHI's goals and objectives, including indebtedness secured by the Capital Obligation Document. The Corporation's Board of Stewardship Trustees also maintains other powers over the Participants, including approval of operating and capital budgets.

Joint Operating Agreements and Joint Ventures. As discussed above, the Corporation is a party to several joint ventures and JOAs. Certain of the JOAs create corporate entities or operating companies to operate health care facilities within a system or network. The Corporation shares certain reserved powers over those corporations or operating companies with the other health system or hospital corporation that is a party to the related joint operating agreement. Each JOA may contain limitations on the ability of CHI entities to transfer property to others, including transfers to CHI and to the other party to the agreement. Such limitations may limit the ability of the applicable Participant to transfer property to CHI if so requested by CHI pursuant to the Capital Obligation Document.

PART IX: CHI LEADERSHIP

Under the leadership of the CEO, CHI has two levels of management, management at the regional level and management at the national office level. CHI operations are overseen by two Presidents who serve as President, Health System Delivery and Chief Operating Officer; and President, Enterprise Business Lines and Chief Financial Officer. The position of President, Health System Delivery and Chief Operating Officer, is currently open; that role is now being filled by an interim executive vice president for operations. Key executives lead mission, strategy, clinical services, physician enterprise, legal services and human resources. CHI's geographic regions are each led by a senior vice president of operations. CHI leverages expertise across the system in areas such as mission, human resources, marketing and communications, finance, legal services, clinical effectiveness, supply chain, information technology, insurance, risk management, and strategy and business development. Several functions have been nationalized including information technology, legal services, clinical engineering and corporate responsibility. Day-to-day operations of the local markets is the responsibility of a local executive who reports to the regional senior vice president of operations. CHI continues to evolve its operating model to include clinical leaders as it moves from a hospital-centric organization to one that provides a full continuum of care in support of the creation of healthier communities.

CHI has strong, experienced leadership teams with a solid understanding of the formation and ongoing management of partnership relationships. Short biographies of key employees are discussed below.

Kevin E. Lofton, FACHE, Chief Executive Officer. Mr. Lofton joined the Corporation in 1998 and has served in his current position since 2003. Prior to that time, he served as Executive Vice President and Chief Operating Officer of the Corporation from 1999 and as the Regional President responsible for markets in seven states from 1998 through 1999. Before joining the Corporation in February 1998, Mr. Lofton was the Chief Executive Officer of the UAB Hospital in Birmingham. In previous positions, Mr. Lofton served as the Chief Executive Officer of Howard University Hospital in Washington, D.C., and Chief Operating Officer at the University of Florida Health Shands Hospital in Jacksonville. Mr. Lofton served as the 2007 Chairman of the Board of the American Hospital Association and on

the board and executive committee of the Catholic Health Association of the United States. Mr. Lofton received a bachelor of science degree in business administration from the Boston University Questrom School of Business and a master of health administration degree from the Georgia State University Robinson College of Business. In May 2016, Mr. Lofton received an honorary doctor of humanities in medicine degree from the Baylor College of Medicine.

J. Dean Swindle, President, Enterprise Business Lines and Chief Financial Officer. Mr. Swindle joined the Corporation in May 2010 and has overall responsibility for financial strategy and planning, and corporate business services, including revenue cycle, supply chain, enterprise support centers, treasury services and payer strategy and operations. In addition, Mr. Swindle leads the Corporation's enterprise business lines including home health, senior living, virtual health services, payer strategy, health plan product offerings and population health resources. Prior to joining the Corporation, Mr. Swindle served as Senior Vice President of Finance, Executive Vice President and Chief Financial Officer and most recently as President, Ambulatory Services and Chief Financial Officer with Novant Health System, Winston-Salem, North Carolina. Mr. Swindle has also served as Vice President, Financial Services, at General Health System in Baton Rouge, Louisiana. He began his career with KPMG LLP in Jackson, Mississippi. Mr. Swindle earned a master of business administration from Duke University Fuqua School of Business in Durham, North Carolina, and a bachelor of business administration degree from Millsaps College, Jackson, Mississippi. He is a member of the Health Care Financial Management Association and the American Institute of Certified Public Accountants.

Anthony Jones, FACHE, Interim Executive Vice President of Operations. Anthony K. Jones is the Executive Vice President and Chief Operating Officer (Interim), and currently serving as the Chief Information Officer (Interim), In his role as COO, Mr. Jones oversees all day-to-day operations including medical affairs, nursing affairs, information technology, quality and patient safety, patient experience, performance excellence and market operations.

Prior to joining the Corporation, Mr. Jones has served in multiple executive capacities, including CEO of the State University of New York (Brooklyn) University Hospital, CEO of Tulare Regional Medical Center in central California, CEO of Dimension Health System in Cheverly, Maryland, and CEO of Ascension St. John Hospital and Medical Center in Detroit, Michigan.

Mr. Jones is a Fellow in the American College of Healthcare Executives (ACHE). Mr. Jones earned his master's in health administration from St. Louis University in St. Louis, Missouri, and a bachelor's degree in business from Abilene Christian University in Abilene, Texas. Mr. Jones is certified in LEAN and Six Sigma and author of the book "Leading a Hospital Turnaround: A Practical Guide." Mr. Jones currently serves on the Board of Directors of Baylor St. Luke's Medical Center, CHI Health, Mercy Medical Center, and the Texas Heart Institute.

Reverend Thomas R. Kopfensteiner, STD, Executive Vice President, Mission. Fr. Kopfensteiner is Executive Vice President of Mission for the Corporation. Prior to joining the Corporation, Fr. Kopfensteiner was previously an associate professor of moral theology and chair of the Department of Theology at Fordham University, Bronx, NY. Fr. Kopfensteiner has written extensively in the area of moral theology and health care ethics. Fr. Kopfensteiner has served as a board member and ethical consultant for several health care organizations. Fr. Kopfensteiner holds a doctorate in sacred theology from Gregorian University in Rome.

Mitch H. Melfi, Esq., Executive Vice President, Corporate Affairs and Chief Legal Officer. Mitch Melfi is the Executive Vice President for Corporate Affairs and Chief Legal Officer. In his current role, Mr. Melfi provides oversight for legal services, including legal mergers and acquisitions, enterprise risk management, corporate governance, audit and tax. Mr. Melfi has also held other positions for the Corporation, including Senior Vice President and General Counsel, Senior Vice President and Chief Risk Officer, and as President and CEO of First Initiatives Insurance, LTD, CHI's wholly owned captive insurance company. Prior to joining the Corporation, Mr. Melfi was the Vice President for Risk/Claim Management and Associate General Counsel for the Sisters of Charity Health Care Systems, Inc. in Cincinnati, Ohio until it merged with two other Catholic health systems to form CHI. Mr. Melfi served was a member of the executive management team for Children's Hospital in Columbus, Ohio, where he provided oversight for all legal operations. Mr. Melfi has authored several publications and spoken on various

legal and risk management topics for lawyers, physicians, nurses, risk managers and other allied healthcare professionals, and has provided consulting services in various areas of risk management and loss prevention.

Mr. Melfi taught at the College of Medicine at The Ohio State University and served as a guest lecturer at Capital University Law School. Mr. Melfi serves on the board of directors of several organizations including health care systems, insurance companies and internal audit. Mr. Melfi received his bachelor of arts from The Ohio State University and his juris doctor from Capital University Law School in Columbus.

Paul W. Edgett, III, Executive Vice President, Chief Strategy Officer. Mr. Edgett joined one of CHI's predecessor health systems in August 1993 as Senior Vice President of Network Services, and most recently served as Executive Vice President, Growth and Business Acquisitions for the Corporation. In his current role, Mr. Edgett provides leadership and direction for enterprise strategic development, strategic transactions, management of JOA and JV investments and formation of strategic partnerships.

Previously, Mr. Edgett was senior vice president of St. Vincent Health System, Little Rock, Arkansas. Prior to that, Mr. Edgett was assistant vice president for Methodist Hospitals of Dallas in Dallas, Texas. Mr. Edgett has also worked for Voluntary Hospitals of America in Irving, Texas, and for Humana, Inc. in Mt. Prospect, Illinois. Mr. Edgett holds a bachelor of arts from Dallas Baptist University and a master of business administration from the University of Colorado.

Patricia G. Webb, Executive Vice President, Chief Administrative Officer and Chief Human Resources Officer. Ms. Webb joined the Corporation in December 2010. She has more than 30 years of experience in leading operations and human resource functions in non-union, union and multi-facility health care organizations. Prior to joining the Corporation, Ms. Webb was Senior Vice President and Chief Human Resources Officer at UMass Memorial Health Care, Worcester, MA. Ms. Webb has also served as human resources executive at Boston Medical Center, Boston, MA; Wake Medical Center, Raleigh, NC; and University Medical Center, Jacksonville, FL. Ms. Webb has a master's degree in business and human resources management from the University of North Florida, Jacksonville; and a bachelor's degree in management and marketing from Florida A&M University, Tallahassee. Ms. Webb is a Fellow in the American College of Health Care Executives and participates frequently on national forums and panels.

Kathleen Sanford, DBA, RN, FACHE, FAAN, Senior Vice President and Chief Nursing Officer. Dr. Sanford joined the Corporation in 2006. She has over 40 years of experience in health care, including staff nursing, middle management, chief nurse executive, hospital administrator, and strategy executive roles. In addition to acute care leadership, she has worked in long term care; founded, initiated and managed a Medicare-certified home health agency; built and managed urgent care services; and managed employed physician office practices. A former Army Nurse, Dr. Sanford retired as Chief Nurse of the Washington Army National Guard. Dr. Sanford served as the 2006 President of the American Organization of Nurse Executives, and in that role, also participated in the Tri-Council for Nursing. She has served on the American Hospital Association Board in addition to multiple regional and local boards. She is currently editor-in-chief for Nursing Administration Quarterly (NAQ). As a former newspaper health care columnist and author of multiple publications, Dr. Sandford has published many articles and the management book, "Leading with Love." Dr. Sanford co-wrote the 2015 management book on Dyad Leadership titled, "Dyad Leadership In Healthcare: When One Plus One Is Greater Than Two." Dr. Sanford education includes a bachelor's degree in Nursing from the University of Maryland/Walter Reed Army Institute of nursing, a master of arts in Human Resources Management from Pepperdine University, a master of business administration from Pacific Lutheran University, and a doctorate in business from Nova Southeastern University. Dr. Sandford is a Fellow in the Wharton School of Business Nursing Administration Program, a Fellow of the American College of Healthcare Executives, and a Fellow of the American Academy of Nursing.

Robert J. Weil, M.D., Senior Vice President and Chief Medical Officer. Dr. Weil joined the Corporation in September 2016 and provides strategic clinical and cultural leadership to ensure the delivery of high-quality, cost-effective and patient-centered care. Among other responsibilities, Dr. Weil manages the clinical service lines, the physician enterprise and CHI's Institute for Research and Innovation ("CIRI").

Previously, Dr. Weil held several roles at Geisinger Health System, including Chief Medical Executive in Northeastern Pennsylvania, Associate Chief Scientific Officer for Clinical and Translational Research for the system, and as Medical Director of Care Support Services, Geisinger's enterprise supply chain and pharmacy division. Prior to joining Geisinger, Dr. Weil was a staff neurosurgeon at the Cleveland Clinic where he was President of Lakewood Hospital in Lakewood, Ohio, part of the Cleveland Clinic Health System. Dr. Weil graduated from Yale College, received his medical degree from the University of Missouri, and a master of business administration from Case Western Reserve University.

PART X: LEGAL PROCEEDINGS

PENDING LITIGATION/REGULATORY MATTERS

CHI operates in a highly litigious industry. As a result, various lawsuits, claims and regulatory proceedings have been instituted or asserted against it from time to time. CHI has knowledge of certain pending suits against certain of its entities that have arisen in the ordinary course of business. In the opinion of management, CHI maintains adequate insurance and/or other financial reserves to cover the estimated potential liability for damages in these cases, or, to the extent such liability is uninsured, adverse decisions will not have a material adverse effect on the financial position or operations of CHI.

General Observation Relating to Status as Health Care System. CHI, like all major health care systems, periodically may be subject to investigations or audits by federal, state and local agencies involving compliance with a variety of laws and regulations. These investigations seek to determine compliance with, among other things, laws and regulations relating to Medicare and Medicaid reimbursement, including billing practices for certain services. Violation of such laws could result in substantial monetary fines, civil and/or criminal penalties and exclusion from participation in Medicare, Medicaid or similar programs.

St. Joseph–London. St. Joseph London ("SJHS") is party to a corporate integrity agreement ("CIA") with the Office of Inspector General that imposes certain compliance oversight obligations solely at SJHS's facility following a 2014 settlement with the federal government, the Commonwealth of Kentucky and others to resolve civil and administrative monetary claims raised in a *qui tam* lawsuit relating to certain diagnostic and therapeutic cardiac procedures performed at SJHS's facility and the financial relationship with certain cardiac physicians and physician groups. The CIA expires in February 2019.

Numerous civil lawsuits were also filed against the Corporation and SJHS claiming damages for alleged unnecessary cardiac stent placements and other cardiac procedures. One such case, *Kevin Ray Wells, Sr. v. Catholic Health Initiatives, et. al.,* Case No. 12-CI-00090 remains unresolved. In August 2016, the jury in that matter found in favor of the plaintiff and awarded compensatory damages in an amount just under $1.3 million and punitive damages of $20.0 million. Post-trial motions were filed and, while the trial court did not set aside the verdict, it did reduce the punitive damage award to $5.0 million. The rulings of the trial court are now being appealed. Oral argument was held on July 13, 2018 in Louisville, Kentucky before a three-judge panel. A decision from the appellate court is pending. Management believes that adequate reserves have been established and that the outcome of the current litigation will not have a material adverse effect on the financial position or results of operations of CHI.

Pension Plan Litigation. As described in greater detail in the Annual Report dated September 15, 2017, in May 2013, the Corporation and two employees were named as defendants in a class action lawsuit under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), challenging the "church plan" status of one of CHI's defined benefit plans. *Medina v. Catholic Health Initiatives, et. al.*, Civil No 13-1249 (District of Colorado). On December 8, 2015, the U.S. District Court for the District of Colorado entered summary judgment in favor of CHI and the individual defendants on all of plaintiff's claims, dismissing the claims with prejudice, and awarding defendants their costs. In a unanimous opinion issued on December 19, 2017, the Tenth Circuit affirmed the District Court's ruling that CHI's plan qualifies as a church plan exempt from ERISA. By written agreement, dated February 14, 2018, plaintiff's counsel confirmed that plaintiff would not appeal the Tenth Circuit's decision in exchange for

defendants foregoing recovery of costs. As a result, this matter is now fully and finally resolved.

Washington State Attorney General Civil Litigation. The Washington State Attorney General's office ("WA AG") filed two civil lawsuits in late summer/early fall of 2017.

In the first action, on August 31, 2017, the WA AG filed a civil lawsuit in the U.S. District Court for the Western District of Washington against Franciscan Health System and Franciscan Medical Group (collectively "CHI Franciscan Health"), and two physician practices, The Doctors Clinic ("TDC") and WestSound Orthopaedics, P.S. ("WSO"). The lawsuit seeks to unwind CHI Franciscan Health's 2016 transactions with TDC and WSO, claiming that they resulted in increased prices and decreased competition for adult primary care and orthopedic physicians' services on Kitsap Peninsula in violation of federal antitrust laws and the Washington Consumer Protection Act, and further seeks monetary disgorgement, civil penalties and fees. The Court has denied both a motion to dismiss from CHI Franciscan Health and an early motion for summary judgment from the WA AG regarding the WA AG's claim that the agreement between CHI Franciscan Health and TDC constitutes *per se* illegal price-fixing, holding that that question cannot be resolved without a full factual record. Discovery is in process. A tentative trial date of March 19, 2019, has been set. No assurance can be given as to the timing or outcome of this litigation matter.

In the second action, on September 5, 2017, the WA AG filed a civil lawsuit in Pierce County Superior Court, Washington, against St. Joseph Medical Center ("SJMC") alleging that SJMC violated the Washington Consumer Protection Act by failing to comply with Washington State's charity care laws and regulations from 2012 to the present, allegedly resulting in a failure to provide charity care to patients who would have qualified for charity care assistance under state law and FHS's charity care policy. The lawsuit seeks civil money penalties, restitution to patients, attorneys' fees and other injunctive relief. Discovery is in process. CHI Franciscan Health has filed an answer to this lawsuit and discovery is proceeding. Both sides have noted summary judgment motions for December 14, 2018. A tentative trial date of February 25, 2019, has been set. No assurance can be given as to the timing or outcome of this litigation matter.

Additionally, on June 22, 2018, an alleged former patient filed a purported class-action lawsuit against CHI Franciscan Health and SJMC in the U.S. District Court for the Western District of Washington, alleging that SJMC violated the Washington Consumer Protection Act, breached the covenant of good faith and fair dealing, and were unjustly enriched, by failing to affirmatively screen her and other similarly situated patients who sought emergency care at SJMC for charity care before engaging in collection efforts, in violation of Washington's charity care laws and regulations. The lawsuit seeks treble damages, restitution, costs, attorneys' fees and injunctive relief. CHI Franciscan Health and SJMC answered the complaint on July 19, 2018. A joint status report is due on September 24, 2018. No other deadlines have been set at this time. No assurance can be given as to the timing or outcome of this litigation matter.

EXHIBIT A
List of Certain CHI Facilities As of June 30, 2018

State / Market	Facilities	Location	Acute Care Facility Licensed Beds	LTC Licensed Beds
Arkansas				
CHI St. Vincent				
	CHI St. Vincent Hospital Hot Springs	Hot Springs	282	
	CHI St. Vincent Infirmary	Little Rock	615	
	CHI St. Vincent Morrilton (CAH)	Morrilton	25	
	CHI St. Vincent North	Sherwood	69	
Colorado and Kansas				
Centura Health[(2)]				
	St. Thomas More Hospital	Canon City	55	
	Progressive Care Center	Canon City		108
	St. Francis Medical Center	Colorado Springs	195	
	Penrose Hospital	Colorado Springs	327	
	Mercy Regional Medical Center	Durango	82	
	St. Anthony Summit Medical Center	Frisco	35	
	OrthoColorado Hospital (Joint Venture)	Lakewood	48	
	St. Anthony Hospital	Lakewood	285	
	Longmont United Hospital	Longmont	186	
	St. Mary-Corwin Medical Center	Pueblo	408	
	St. Anthony North Health Campus	Westminster	100	
	St. Catherine Hospital	Garden City (Kansas)	100	
	Bob Wilson Memorial Grant County Hospital	Ulysses (Kansas)	26	
Iowa and Nebraska				
Mercy Health Network (Iowa)[(3)]				
	Mercy Medical Center - Centerville (CAH)	Centerville	25	20
	Mercy Medical Center	Des Moines	656	
	Skiff Medical Center	Newton	48	
	Mercy Medical Center West Lakes	West Des Moines	146	
CHI Health				
	CHI Health Mercy Corning (CAH)	Corning (Iowa)	22	
	CHI Health Mercy Council Bluffs	Council Bluffs (Iowa)	278	
	CHI Health Missouri Valley (CAH)	Missouri Valley (Iowa)	25	
	CHI Health St. Francis and St Francis Memorial Health Center	Grand Island (Nebraska)	159	58
	CHI Health Good Samaritan	Kearney (Nebraska)	233	22
	CHI Health Richard Young Behavioral Health	Kearney (Nebraska)	61	

This document is dated as of September 28, 2018

State / Market	Facilities(1)	Location	Acute Care Facility Licensed Beds	LTC Licensed Beds
	CHI Health Nebraska Heart	Lincoln (Nebraska)	63	
	CHI Health St. Elizabeth	Lincoln (Nebraska)	260	
	CHI Health St. Mary's (CAH)	Nebraska City (Nebraska)	18	
	CHI Health Creighton University Medical Center - Bergan Mercy	Omaha (Nebraska)	400	
	Lasting Hope Recovery Center	Omaha (Nebraska)	64	
	CHI Health Immanuel	Omaha (Nebraska)	345	
	CHI Health Lakeside	Omaha (Nebraska)	157	
	CHI Health Midlands	Papillion (Nebraska)	121	
	CHI Health Plainview (CAH)	Plainview (Nebraska)	15	
	CHI Health Schuyler (CAH)	Schuyler (Nebraska)	25	
Kentucky				
KentuckyOne Health, Inc.				
	Flaget Memorial Hospital	Bardstown	40	12
	Saint Joseph -Berea (CAH)	Berea	25	
	Saint Joseph East, including Women's Hospital at Saint Joseph East	Lexington	217	
	Saint Joseph Hospital	Lexington	408	
	Saint Joseph-London	London	150	
	Frazier Rehabilitation and Neuroscience Center(4)	Louisville	135	
	Jewish Hospital(4)	Louisville	462	
	Our Lady of Peace	Louisville	396	
	Sts. Mary & Elizabeth Hospital(4)	Louisville	298	
	Saint Joseph-Martin (CAH) (5)	Martin	25	
	Saint Joseph-Mount Sterling	Mount Sterling	42	
	Jewish Hospital Shelbyville	Shelbyville	70	
Minnesota				
CHI Lakewood Health				
	CHI Lakewood Health (Hospital) (CAH)	Baudette	15	
CHI St. Francis Health				
	St. Francis Home	Breckenridge		80
	CHI St. Francis Health (Hospital) (CAH)	Breckenridge	25	
Unity Family Healthcare				
	CHI St. Gabriel's Health (Hospital) (CAH)	Little Falls	25	

State / Market	Facilities[1]	Location	Acute Care Facility Licensed Beds	LTC Licensed Beds
CHI St. Joseph's Health				
	CHI St. Joseph's Health (Hospital) (CAH)	Park Rapids	54	
North Dakota				
CHI Villa Nazareth				
	CHI Villa Nazareth	Fargo		90
CHI Lisbon Health				
	CHI Lisbon Health (Hospital) (CAH)	Lisbon	25	
CHI Oakes Hospital				
	CHI Oakes Hospital (CAH)	Oakes	20	
CHI St. Alexius Health				
	CHI St. Alexius Medical Center	Bismarck	306	
	CHI St. Alexius Turtle Lake (CAH)	Turtle Lake	25	
	CHI St. Alexius Health Garrison (CAH)	Garrison	22	28
	CHI St. Alexius Health Carrington (CAH)	Carrington	25	
	CHI St. Alexius Health Devils Lake (CAH)	Devils Lake	25	
	CHI St. Alexius Health Williston (CAH)	Williston	25	
	CHI St. Alexius Health Dickinson (Hospital) (CAH)	Dickinson	25	
CHI Mercy Health				
	CHI Mercy Health (Hospital) (CAH)	Valley City	25	
Ohio				
Sylvania Franciscan Health				
CHI Living Communities *Ohio, Colorado, and Iowa*				
	Medalion Retirement Community	Colorado Springs (Colorado)		60
	Namaste Alzheimer Center	Colorado Springs (Colorado)		64
	The Gardens at St. Elizabeth	Denver (Colorado)		126
	The Villas at Sunny Acres	Thornton (Colorado		134
	Bishop Drumm Retirement Center	Johnston (Iowa)		150
	Franciscan Care Center	Sylvania		109
	Madonna Manor	Villa Hills		60
	Providence Care Center	Sandusky		138
	St. Clare Commons	Perrysburg		60
	St. Leonard	Centerville		150

State / Market	Facilities(1)	Location	Acute Care Facility Licensed Beds	LTC Licensed Beds
Trinity Health System				
	Trinity East	Steubenville	194	50
	Trinity West	Steubenville	238	
Trinity Hospital Twin City				
	Trinity Hospital Twin City (CAH)	Dennison	25	
TriHealth, Inc.				
	Good Samaritan Hospital[6]	Cincinnati	502	
Oregon				
Mercy Medical Center				
	Mercy Medical Center	Roseburg	174	
St. Anthony Hospital				
	St. Anthony Hospital (CAH)	Pendleton	49	
Tennessee				
CHI Memorial				
	Memorial Hospital	Chattanooga	349	
	Memorial Hospital-Hixson	Hixson	75	
	Memorial Hospital-Georgia	Fort Oglethorpe	179	
Texas				
CHI St. Luke's Health				
	Brazosport Regional Health System	Lake Jackson	158	
	St. Luke's Hospital at The Vintage	Houston	106	
	Baylor St. Luke's Medical Center[7]	Houston	879	
	Patients Medical Center	South Pasadena	61	
	St. Luke's Sugar Land Hospital	Sugar Land	100	
	St. Luke's Lakeside Hospital	The Woodlands	30	
	St. Luke's The Woodlands Hospital	The Woodlands	231	
	CHI St. Luke's Health Springwoods Village	Spring	4	
CHI St. Luke's Health - Memorial				
	CHI St. Luke's Health Memorial Livingston	Livingston	66	
	CHI St. Luke's Health Memorial Lufkin	Lufkin	271	
	CHI St. Luke's Memorial Specialty Hospital[8]	Lufkin		26
	CHI St. Luke's Memorial San Augustine (CAH)	San Augustine	18	
CHI St. Joseph Health				
	CHI St. Joseph Health Bellville Hospital	Bellville	**30**	
	CHI St. Joseph Health Burleson Hospital (CAH)	Caldwell	**25**	
	CHI St. Joseph Health Madison Hospital (CAH)	Madisonville	**25**	
	St. Joseph Manor	Bryan		88

State / Market	Facilities (1)	Location	Acute Care Facility Licensed Beds	LTC Licensed Beds
	CHI St. Joseph Health Regional Hospital	Bryan	235	
	CHI St. Joseph Health Grimes Hospital	Navasota	25	
Washington				
CHI Franciscan Health				
	Harrison Medical Center	Bremerton, Silverdale	336	
	Highline Medical Center	Burien	133	
	Regional Hospital for Respiratory and Complex Care	Burien	40	
	St. Anthony Hospital	Gig Harbor	112	
	St. Clare Hospital	Lakewood	106	
	St. Elizabeth Hospital (CAH)	Enumclaw	38	
	St. Francis Hospital	Federal Way	124	
	St. Joseph Medical Center	Tacoma	366	
Wisconsin				
CHI Franciscan Villa				
	CHI Franciscan Villa	South Milwaukee		150

(1) (CAH) denotes a Critical Access Hospital.

(2) These facilities operated under the Centura Health (Colorado) Joint Operating Agreement.

(3) These facilities operated under the Mercy Health Network (Iowa) Joint Operating Agreement.

(4) These facilities are part of the planned divestiture described in *Part V: Strategic Affiliations and Acquisitions-Pending and Completed Divestitures, KentuckyOne Health*

(5) This facility was sold July 1, 2018.

(6) Operated under the TriHealth Inc. (Ohio) Joint Operating Agreement

(7) This facility managed and operated under the Joint Operating Agreement with Baylor College of Medicine.

(8) This facility was sold July 1, 2018.

APPENDIX A

CATHOLIC HEALTH INITIATIVES

CONSOLIDATED FINANCIAL STATEMENTS

AND SUPPLEMENTAL INFORMATION

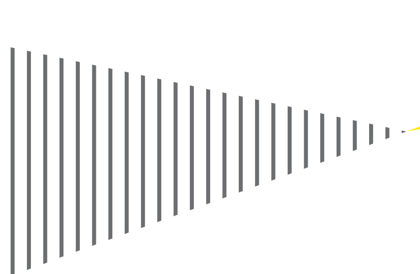
YEARS ENDED JUNE 30, 2018 AND 2017

This document is dated as of September 28, 2018

CONSOLIDATED FINANCIAL STATEMENTS
AND SUPPLEMENTARY INFORMATION

Catholic Health Initiatives
Years Ended June 30, 2018 and 2017
With Report of Independent Auditors

Ernst & Young LLP



Catholic Health Initiatives

Consolidated Financial Statements
and Supplementary Information

Years Ended June 30, 2018 and 2017

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1809-2862845

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Report of Independent Auditors

The Board of Stewardship Trustees
Catholic Health Initiatives

We have audited the accompanying consolidated financial statements of Catholic Health Initiatives, which comprise the consolidated balance sheets as of June 30, 2018 and 2017, and the related consolidated statements of operations, changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity 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 financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the 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 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 financial statements.

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

A member firm of Ernst & Young Global Limited

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Catholic Health Initiatives as of June 30, 2018 and 2017, and the consolidated results of its operations and its cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Ernst & Young LLP

September 27, 2018

A member firm of Ernst & Young Global Limited

Catholic Health Initiatives

Consolidated Balance Sheets
(In Thousands)

	June 30	
	2018	**2017**
Assets		
Current assets:		
Cash and equivalents	**$ 510,456**	$ 810,235
Net patient accounts receivable, less allowances for bad debts of $827,130 and $955,830 at June 30, 2018 and 2017, respectively	**2,121,582**	2,064,050
Other accounts receivable	**257,285**	249,350
Current portion of investments and assets limited as to use	**64,348**	65,161
Inventories	**298,636**	290,267
Assets of discontinued operations and held for sale	**195,698**	1,187,811
Prepaid and other	**144,003**	153,160
Total current assets	**3,592,008**	4,820,034
Investments and assets limited as to use:		
Internally designated for capital and other funds	**5,308,868**	5,546,290
Held by trustees	**76,080**	76,850
Held for insurance purposes	**829,402**	876,370
Restricted by donors	**258,513**	258,511
Total investments and assets limited as to use	**6,472,863**	6,758,021
Property and equipment, net	**8,110,767**	8,378,161
Investments in unconsolidated organizations	**1,732,840**	1,320,017
Intangible assets and goodwill, net	**421,388**	420,659
Notes receivable and other	**265,441**	234,858
Total assets	**$ 20,595,307**	$ 21,931,750

Continued on following page

Catholic Health Initiatives

Consolidated Balance Sheets (continued)

(In Thousands)

	June 30	
	2018	**2017**
Liabilities and net assets		
Current liabilities:		
Compensation and benefits	**$ 568,986**	$ 632,857
Third-party liabilities, net	**131,670**	91,008
Accounts payable and accrued expenses	**1,480,365**	1,550,536
Liabilities of discontinued operations and held for sale	**251,710**	492,440
Variable-rate debt with self-liquidity	**96,700**	96,700
Commercial paper and current portion of debt	**2,087,406**	2,016,042
Total current liabilities	**4,616,837**	4,879,583
Pension liability	**854,427**	1,110,983
Self-insured reserves and claims	**623,267**	633,392
Other liabilities	**1,027,091**	1,053,632
Long-term debt	**6,341,931**	6,527,426
Total liabilities	**13,463,553**	14,205,016
Net assets:		
Net assets attributable to CHI	**6,528,635**	7,047,905
Net assets attributable to noncontrolling interests	**300,428**	367,483
Unrestricted	**6,829,063**	7,415,388
Temporarily restricted	**207,695**	214,250
Permanently restricted	**94,996**	97,096
Total net assets	**7,131,754**	7,726,734
Total liabilities and net assets	**$ 20,595,307**	$ 21,931,750

See accompanying notes.

Catholic Health Initiatives

Consolidated Statements of Operations
(In Thousands)

	Year Ended June 30	
	2018	**2017**
Revenues:		
Net patient services revenues before provision for doubtful accounts	**$ 14,903,723**	$ 14,806,472
Provision for doubtful accounts	**(767,349)**	(843,705)
Net patient services revenues	**14,136,374**	13,962,767
Other operating revenues:		
Donations	**41,753**	30,954
Changes in equity of unconsolidated organizations	**18,458**	48,404
Hospital ancillary revenues	**350,321**	321,211
Other	**435,181**	679,334
Total other operating revenues	**845,713**	1,079,903
Total operating revenues	**14,982,087**	15,042,670
Expenses:		
Salaries and wages	**5,995,955**	6,157,237
Employee benefits	**1,114,564**	1,172,480
Purchased services, medical professional fees and consulting	**2,301,000**	2,285,741
Supplies	**2,447,516**	2,446,952
Utilities	**196,428**	203,984
Rentals, leases, maintenance and insurance	**883,442**	888,222
Depreciation and amortization	**856,188**	824,386
Interest	**312,771**	289,732
Other	**1,009,653**	1,004,187
Total operating expenses before restructuring, impairment and other losses	**15,117,517**	15,272,921
Loss from operations before restructuring, impairment and other losses	**(135,430)**	(230,251)
Restructuring, impairment and other losses	**141,283**	363,191
Loss from operations	**(276,713)**	(593,442)
Nonoperating gains (losses):		
Investment gains, net	**442,496**	629,216
Gains (losses) on early extinguishment of debt	**208**	(19,586)
Realized and unrealized gains on interest rate swaps	**52,123**	92,698
Other nonoperating gains	**3,987**	2,007
Total nonoperating gains	**498,814**	704,335
Excess of revenues over expenses	**222,101**	110,893
Excess of revenues over expenses attributable to noncontrolling interests	**28,449**	19,948
Excess of revenues over expenses attributable to CHI	**$ 193,652**	$ 90,945

See accompanying notes.

Catholic Health Initiatives

Consolidated Statements of Changes in Net Assets

(In Thousands)

	Unrestricted Net Assets					
	Attributable to CHI	**Attributable to Noncontrolling Interests**	**Total**	**Temporarily Restricted Net Assets**	**Permanently Restricted Net Assets**	**Total Net Assets**
Balances, July 1, 2016	$ 6,704,217	$ 423,424	$ 7,127,641	$ 224,524	$ 94,931	$ 7,447,096
Excess of revenues over expenses	90,945	19,948	110,893	–	–	110,893
Net loss from discontinued operations	(116,300)	(18,500)	(134,800)	–	–	(134,800)
Change in pension funded status	335,923	73	335,996	–	–	335,996
Temporarily and permanently restricted contributions	–	–	–	40,754	2,034	42,788
Net assets released from restriction for capital	33,737	–	33,737	(33,737)	–	–
Net assets released from restriction for operations	–	–	–	(19,939)	–	(19,939)
Investment (losses) income	(423)	–	(423)	7,811	1,113	8,501
Distributions to noncontrolling owners	–	(28,935)	(28,935)	–	–	(28,935)
Other changes in net assets	(194)	(28,527)	(28,721)	(5,163)	(982)	(34,866)
Net increase (decrease) in net assets	343,688	(55,941)	287,747	(10,274)	2,165	279,638
Balances, June 30, 2017	7,047,905	367,483	7,415,388	214,250	97,096	7,726,734
Excess of revenues over expenses	**193,652**	**28,449**	**222,101**	**–**	**–**	**222,101**
Net loss from discontinued operations	**(790,493)**	**(3,261)**	**(793,754)**	**–**	**–**	**(793,754)**
Change in pension funded status	**139,204**	**4,360**	**143,564**	**–**	**–**	**143,564**
Temporarily and permanently restricted contributions	**–**	**–**	**–**	**41,883**	**563**	**42,446**
Net assets released from restriction for capital	**20,584**	**–**	**20,584**	**(20,584)**	**–**	**–**
Net assets released from restriction for operations	**–**	**–**	**–**	**(26,552)**	**–**	**(26,552)**
Investment income	**–**	**–**	**–**	**4,760**	**697**	**5,457**
Distributions to noncontrolling owners	**–**	**(33,384)**	**(33,384)**	**–**	**–**	**(33,384)**
Purchase of noncontrolling interest	**(91,483)**	**(63,968)**	**(155,451)**	**–**	**–**	**(155,451)**
Other changes in net assets	**9,266**	**749**	**10,015**	**(6,062)**	**(3,360)**	**593**
Net decrease in net assets	**(519,270)**	**(67,055)**	**(586,325)**	**(6,555)**	**(2,100)**	**(594,980)**
Balances, June 30, 2018	**$ 6,528,635**	**$ 300,428**	**$ 6,829,063**	**$ 207,695**	**$ 94,996**	**$ 7,131,754**

See accompanying notes.

Catholic Health Initiatives

Consolidated Statements of Cash Flows

(In Thousands)

	Year Ended June 30	
	2018	**2017**
Operating activities		
(Decrease) increase in net assets	**$ (594,980)**	$ 279,638
Adjustments to reconcile (decrease) increase in net assets to net cash provided by operating activities:		
Loss on deconsolidation of subsidiary	**319,167**	–
Purchase of noncontrolling interest	**155,451**	–
Depreciation and amortization	**856,188**	824,386
Provision for bad debts	**767,349**	843,705
Changes in equity of unconsolidated organizations	**(18,458)**	(48,404)
Net gains on sales of facilities and investments in unconsolidated organizations	**(46,105)**	(195,583)
Noncash operating expenses related to restructuring, impairment and other losses	**14,244**	107,723
Noncash operating expenses related to impairment of long-lived assets of discontinued operations	**377,519**	–
(Gains) losses on early extinguishment of debt	**(208)**	19,586
Change in fair value of interest rate swaps	**(79,596)**	(127,866)
Noncash pension adjustments	**(139,773)**	(345,344)
Pension cash contributions	**(116,782)**	(79,513)
Net changes in current assets and liabilities:		
Net patient and other accounts receivable	**(916,987)**	(850,461)
Other current assets	**(3,557)**	(27,796)
Current liabilities	**(70,595)**	(101,894)
Other changes	**33,871**	22,535
Net cash provided by operating activities, before net change in investments and assets limited as to use	**536,748**	320,712
Net decrease (increase) in investments and assets limited as to use	**198,352**	(246,020)
Net cash provided by operating activities	**735,100**	74,692
Investing activities		
Purchases of property, equipment, and other capital assets	**(759,713)**	(705,147)
Investments in unconsolidated organizations	**(110,020)**	(106,082)
Business acquisitions, net of cash acquired	**(20,753)**	(64,432)
Proceeds from asset sales	**60,814**	597,434
Distributions from investments in unconsolidated organizations	**50,119**	39,696
(Issuance) repayments of notes receivable, net	**(17,978)**	144,433
Other changes	**1,473**	(12,380)
Net cash used in investing activities	**(796,058)**	(106,478)
Financing activities		
Proceeds from issuance of debt and bank loans	**909,620**	240,129
Repayment of debt and bank loans	**(1,043,783)**	(636,114)
Swap cash collateral received	**84,177**	82,036
Distributions to noncontrolling owners	**(33,384)**	(15,541)
Purchase of noncontrolling interest	**(155,451)**	–
Net cash used in financing activities	**(238,821)**	(329,490)
Decrease in cash and equivalents	**(299,779)**	(361,276)
Cash and equivalents at beginning of period	**810,235**	1,171,511
Cash and equivalents at end of period	**$ 510,456**	$ 810,235
Supplemental disclosures of noncash investing activity		
Noncash purchases of property and equipment	**$ 43,537**	$ 53,881
Supplemental disclosures of cash flow information		
Cash paid during the year for interest, including amounts capitalized	**$ 338,488**	$ 326,131

See accompanying notes.

1. Summary of Significant Accounting Policies

Organization

Catholic Health Initiatives (CHI), established in 1996, is a tax-exempt Colorado corporation and has been granted an exemption from federal income tax under Section 501(c)(3) of the Internal Revenue Code. CHI sponsors market-based organizations (MBOs) and other facilities operating in 18 states and comprises 100 hospitals, including two academic health centers, major teaching hospitals and 29 critical access facilities; community health services organizations; accredited nursing colleges; home health agencies; living communities; and other facilities and services that span the inpatient and outpatient continuum of care. CHI also has an offshore captive insurance company, First Initiatives Insurance, Ltd. (FIIL).

The mission of CHI is to nurture the healing ministry of the Church, supported by education and research. Fidelity to the Gospel urges CHI to emphasize human dignity and social justice as CHI creates healthier communities.

Principles of Consolidation

CHI consolidates all direct affiliates in which it has sole corporate membership or ownership (Direct Affiliates) and all entities in which it has greater than 50% equity interest with commensurate control. All significant intercompany accounts and transactions are eliminated in consolidation.

Fair Value of Financial Instruments

Financial instruments consist primarily of cash and equivalents, patient accounts receivable, investments and assets limited as to use, notes receivable and accounts payable. The carrying amounts reported in the consolidated balance sheets for these items, other than investments and assets limited as to use, approximate fair value. See Note 8, *Fair Value of Assets and Liabilities*, for a discussion of the fair value of investments and assets limited as to use.

1. Summary of Significant Accounting Policies (continued)

Cash and Equivalents

Cash and equivalents include all deposits with banks and investments in interest-bearing securities with maturity dates of 90 days or less from the date of purchase. In addition, cash and equivalents include deposits in short-term funds held by professional managers. The funds generally invest in high-quality, short-term debt securities, including U.S. government securities, securities issued by domestic and foreign banks, such as certificates of deposit and bankers' acceptances, repurchase agreements, asset-backed securities, high-grade commercial paper, and corporate short-term obligations.

Net Patient Accounts Receivable and Net Patient Services Revenues

Net patient accounts receivable has been adjusted to the estimated amounts expected to be collected. These estimated amounts are subject to further adjustments upon review by third-party payors.

The provision for bad debts is based upon management's assessment of historical and expected net collections, taking into consideration historical business and economic conditions, trends in health care coverage, and other collection indicators. Management routinely assesses the adequacy of the allowances for uncollectible accounts based upon historical write-off experience by payor category. The results of these reviews are used to modify, as necessary, the provision for bad debts and to establish appropriate allowances for uncollectible net patient accounts receivable. After satisfaction of amounts due from insurance, CHI follows established guidelines for placing certain patient balances with collection agencies, subject to the terms of certain restrictions on collection efforts as determined by each facility. The provision for bad debts is presented in the consolidated statement of operations as a deduction from patient services revenues (net of contractual allowances and discounts) since CHI accepts and treats all patients without regard to the ability to pay.

1. Summary of Significant Accounting Policies (continued)

Details of CHI's allowance activity is as follows (in thousands):

	Reserve for Contractual Allowance	Allowance for Bad Debts	Reserve for Charity	Total Accounts Receivable Allowances
Balance at July 1, 2016	$ (3,553,575)	$ (909,994)	$ (171,921)	$ (4,635,490)
Additions	(34,877,877)	(843,705)	(1,046,622)	(36,768,204)
Reductions	34,993,719	797,869	998,438	36,790,026
Balance at June 30, 2017	(3,437,733)	(955,830)	(220,105)	(4,613,668)
Additions	**(36,589,384)**	**(767,349)**	**(933,570)**	**(38,290,303)**
Reductions	**36,727,665**	**896,049**	**873,228**	**38,496,942**
Balance at June 30, 2018	**$ (3,299,452)**	**$ (827,130)**	**$ (280,447)**	**$ (4,407,029)**

CHI records net patient services revenues in the period in which services are performed. CHI has agreements with third-party payors that provide for payments at amounts different from its established rates. The basis for payment under these agreements includes prospectively determined rates, cost reimbursement and negotiated discounts from established rates, and per diem payments.

Net patient services revenues are reported at the estimated net realizable amounts from patients, third-party payors and others for services rendered, including estimated retroactive adjustments due to future audits, reviews and investigations, and excluding estimated amounts considered uncollectible. The differences between the estimated and actual adjustments are recorded as part of net patient services revenues in future periods, as the amounts become known, or as years are no longer subject to such audits, reviews and investigations.

Investments and Assets Limited as to Use

Investments and assets limited as to use include assets set aside by CHI for future long-term purposes, including capital improvements and self-insurance. In addition, assets limited as to use include amounts held by trustees under bond indenture agreements, amounts contributed by donors with stipulated restrictions and amounts held for Mission and Ministry programs.

CHI has designated its investment portfolio as trading as the portfolio is actively managed to achieve investment returns. Accordingly, unrealized gains and losses on marketable securities are reported within excess of revenues over expenses. In addition, cash flows from the purchases and sales of marketable securities are reported as a component of operating activities in the accompanying consolidated statements of cash flows.

1. Summary of Significant Accounting Policies (continued)

Direct investments in equity securities with readily determinable fair values and all direct investments in debt securities have been measured at fair value in the accompanying consolidated balance sheets. Investment income or loss (including realized gains and losses on investments, interest and dividends) is included in excess of revenues over expenses unless the income or loss is restricted by donor or law.

Investments in limited partnerships and limited liability companies are recorded using the equity method of accounting (which approximates fair value as determined by the net asset values of the related unitized interests) with the related changes in value in earnings reported as investment income in the accompanying consolidated financial statements.

Inventories

Inventories, primarily consisting of pharmacy drugs, and medical and surgical supplies, are stated at lower of cost (first-in, first-out method) or market.

Assets and Liabilities of Discontinued Operations and Held for Sale

Assets and liabilities of discontinued operations and held for sale represent assets and liabilities that are expected to be sold within one year or were disposed of other than by sale. A group of assets and liabilities expected to be sold within one year is classified as held for sale if it meets certain criteria. The assets and liabilities of discontinued operations held for sale are measured at the lower of carrying value or fair value less costs to sell. Such valuations include estimates of fair values generally based upon firm offers, discounted cash flows and incremental direct costs to transact a sale (Level 2 and Level 3 inputs).

Property and Equipment

Property and equipment are stated at historical cost or, if donated or impaired, at fair value at the date of receipt or impairment. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Buildings and improvements are depreciated over estimated useful lives of 5 to 84 years, equipment over 3 to 30 years, and land improvements over 2 to 25 years. For property and equipment under capital lease, amortization is determined over the shorter period of the lease term or the estimated useful life of the property and equipment.

1. Summary of Significant Accounting Policies (continued)

Interest cost incurred during the period of construction of major capital projects is capitalized as a component of the cost of acquiring those assets. Capitalized interest of $8.5 million and $12.9 million was recorded in the fiscal years ended June 30, 2018 and 2017, respectively.

Costs incurred in the development and installation of internal-use software are expensed if they are incurred in the preliminary project stage or post-implementation stage, while certain costs are capitalized if incurred during the application development stage. Internal-use software is amortized over its expected useful life, generally between 2 and 15 years, with amortization beginning when the project is completed and the software is placed in service.

Investments in Unconsolidated Organizations

Investments in unconsolidated organizations are accounted for under the cost or equity method of accounting, as appropriate, based on the relative percentage of ownership or degree of influence over that organization. The income or loss on the equity method investments is recorded in the consolidated statements of operations as changes in equity of unconsolidated organizations.

Intangible Assets and Goodwill

Intangible assets are comprised primarily of trade names, which are amortized over the estimated useful lives ranging from 10 to 25 years using the straight-line method. The weighted average useful life of the trade names is 16 years. Amortization expense of $9.5 million and $12.6 million was recorded in the fiscal years ended June 30, 2018 and 2017, respectively.

Goodwill is not amortized but is subject to annual impairment tests during the third quarter of the fiscal year, as well as more frequent reviews whenever circumstances indicate a possible impairment may exist; no such circumstances were identified at June 30, 2018 and at June 30, 2017, with the exception of the Houston MBO discussed below. Impairment testing of goodwill is performed at the reporting unit level by comparing the fair value of the reporting unit's net assets against the carrying value of the reporting unit's net assets, including goodwill. Each MBO is defined as a reporting unit for purposes of impairment testing. The fair value of the reporting unit's net assets is generally estimated based on quantitative analysis of discounted cash flows (Level 3 measurement). The fair value of goodwill is determined by assigning fair values to assets and liabilities, with the remaining fair value reported as the implied fair value of goodwill.

1. Summary of Significant Accounting Policies (continued)

During fiscal year 2017, the Houston MBO acquired various physician and diagnostic operations in Texas, which resulted in the recognition of $43.9 million of total goodwill, calculated as the difference between the consideration paid and the fair value of assets acquired and liabilities assumed. Goodwill impairment reviews of the Houston MBO during fiscal year 2017 indicated that the $43.9 million of goodwill attributable to the Houston MBO was impaired, and total goodwill impairment charges of $43.9 million were recorded in the consolidated statement of operations for the fiscal year ended June 30, 2017.

The changes in the carrying amount of goodwill and intangibles for the years ended June 30 are as follows (in thousands):

	2018	2017
Intangible assets, beginning of year	**$ 236,034**	$ 251,776
Acquisitions	**1,084**	4,783
Sales and other adjustments	**(3,833)**	(20,525)
Intangible assets, end of year	**233,285**	236,034
Accumulated amortization, beginning of year	**(47,370)**	(50,680)
Intangible amortization expense	**(9,477)**	(12,581)
Sales and other adjustments	**5,259**	15,891
Accumulated amortization, end of year	**(51,588)**	(47,370)
Intangible assets, net	**181,697**	188,664
Goodwill, beginning of year	**231,995**	208,564
Acquisitions	**11,459**	67,567
Impairments and dispositions	**(3,763)**	(44,136)
Goodwill, end of year	**239,691**	231,995
Total intangible assets and goodwill, net	**$ 421,388**	$ 420,659

Notes Receivable and Other Assets

Other assets consist primarily of notes receivable, pledges receivable, deferred compensation assets, long-term prepaid service contracts, deposits and other long-term assets.

1. Summary of Significant Accounting Policies (continued)

A summary of notes receivable and other assets is as follows as of June 30 (in thousands):

	2018	2017
Notes receivable:		
From related entities	**$ 16,842**	$ 135
Other	**35,566**	20,560
Long-term pledge receivables	**36,387**	37,911
Reinsurance recoverable on unpaid losses and loss adjustment expense	**39,772**	29,089
Deferred compensation assets	**57,466**	58,558
Other long-term assets	**79,408**	88,605
Total notes receivable and other	**$ 265,441**	$ 234,858

Net Assets

Temporarily restricted net assets are those whose use has been limited by donors to a specific time period or purpose. Permanently restricted net assets consist of gifts with corpus values that have been restricted by donors to be maintained in perpetuity, including endowment funds. Temporarily restricted net assets and earnings on permanently restricted net assets, including earnings on endowment funds, are used in accordance with the donor's wishes primarily to purchase equipment, to provide charity care, and to provide other health and educational programs and services.

Unconditional promises to receive cash and other assets are reported at fair value at the date the promise is received. Conditional promises and indications of donors' intentions to give are reported at fair value at the date the conditions are met or the gifts are received. All unrestricted contributions are included in the excess of revenue over expenses as donation revenues. Other gifts are reported as either temporarily or permanently restricted if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as donations revenue when restricted for operations or as unrestricted net assets when restricted for property and equipment.

1. Summary of Significant Accounting Policies (continued)

Performance Indicator

The performance indicator is the excess of revenues over expenses, which includes all changes in unrestricted net assets other than changes in the pension liability funded status, net assets released from restrictions for property acquisitions, cumulative effect of changes in accounting principles, discontinued operations, contributions of property and equipment, and other changes not required to be included within the performance indicator under U.S. GAAP.

Operating and Nonoperating Activities

CHI's primary mission is to meet the health care needs in its market areas through a broad range of general and specialized health care services, including inpatient acute care, outpatient services, physician services, long-term care, and other health care services. Activities directly associated with the furtherance of this purpose are considered to be operating activities. Other activities that result in gains or losses peripheral to CHI's primary mission are considered to be nonoperating. Nonoperating activities include investment earnings, gains/losses from extinguishment of debt, net interest cost and changes in fair value of interest rate swaps, and the nonoperating component of Joint Operating Agreement (JOA) income share adjustments. Any infrequent and nonreciprocal contribution that CHI makes to enter a new market community or to expand upon existing affiliations is also classified as nonoperating.

Charity Care

As an integral part of its mission, CHI accepts and provides medically necessary health care to all patients without regard to the patient's financial ability to pay. Services to patients are classified as charity care in accordance with standards established across all MBOs. Charity care represents services rendered for which partial or no payment is expected, and includes the cost of providing services to persons who cannot afford health care due to inadequate resources and/or who are uninsured or underinsured. CHI determines the cost of charity care on the basis of an MBO's total cost as a percentage of total charges applied to the charges incurred by patients qualifying for charity care under CHI's policy. This amount is not included in net patient services revenue in the accompanying consolidated statements of operations and changes in net assets. The estimated cost of charity care provided was $226.2 million and $240.8 million in fiscal years 2018 and 2017, respectively, for continuing operations, and $18.3 million and $25.8 million in fiscal years 2018 and 2017, respectively, for discontinued operations.

1. Summary of Significant Accounting Policies (continued)

Other Operating Revenues

Other operating revenues include services sold to external health care providers, gains on acquisitions of subsidiaries, cafeteria sales, rental income, retail pharmacy and durable medical equipment sales, auxiliary and gift shop revenues, electronic health records incentive payments, gains and losses on asset disposals, the operating portion of revenue-sharing income or expense associated with Direct Affiliates that are part of JOAs, premium revenues, and revenues from other miscellaneous sources.

Derivative and Hedging Instruments

CHI uses derivative financial instruments (interest rate swaps) in managing its capital costs. These interest rate swaps are recognized at fair value on the consolidated balance sheets. CHI has not designated its interest rate swaps related to CHI's long-term debt as hedges. The net interest cost and change in the fair value of such interest rate swaps is recognized as a component of nonoperating gains (losses) in the accompanying consolidated statements of operations. It is CHI's policy to net the value of collateral on deposit with counterparties against the fair value of its interest rate swaps in other liabilities on the consolidated balance sheets.

Functional Expenses

CHI provides healthcare services, including inpatient, outpatient, ambulatory, long-term care and community-based services to individuals within the various geographic areas supported by its facilities. Support services include administration, finance and accounting, information technology, public relations, human resources, legal, mission services, and other functions that are supported centrally for all of CHI. Support services expenses as a percentage of total operating expenses were approximately 5.8% and 6.2% in 2018 and 2017, respectively.

Restructuring, Impairment and Other Losses

Restructuring, impairment and other losses include charges relating to changes in business operations, severance costs, EPIC go-live support costs, goodwill and long-lived asset impairments, acquisition-related costs, and pension settlement activity. Changes in business operations include costs incurred periodically to implement reorganization efforts within specific operations, in order to align CHI's operations in the most strategic and cost-effective manner.

1. Summary of Significant Accounting Policies (continued)

Details of CHI's restructuring, impairment and other losses for the years ended June 30 are as follows (in thousands):

	2018	2017
Changes in business operations	**$ 40,043**	$ 206,297
Severance costs	**33,810**	68,860
Impairment charges	**14,231**	48,356
Pension settlement costs	**53,199**	39,678
Restructuring, impairment and other losses from continuing operations	**$ 141,283**	$ 363,191
Restructuring, impairment and other losses from discontinued operations	**$ 724,198**	$ 25,517

Discontinued operations are reported in the consolidated statements of changes in net assets. For the year ended June 30, 2018, discontinued operations include total impairment charges of $377.5 million to reduce the carrying value of the Jewish Hospital and St. Mary's Healthcare, Inc. System's (JHSMH) long-lived assets to their estimated fair value, less estimated costs to sell, as a result of the anticipated sale of their operations. For the year ended June 30, 2018, discontinued operations also include a $319.2 million loss on deconsolidation of UMC – see Note 5, *Assets and Liabilities of Discontinued Operations and Held for Sale*.

Income Taxes

CHI is a tax-exempt Colorado corporation and has been granted an exemption from federal income tax under Section 501(c)(3) of the Internal Revenue Code. CHI owns certain taxable subsidiaries and engages in certain activities that are unrelated to its exempt purpose and, therefore, subject to income tax. As of June 30, 2018, CHI has a deferred tax asset of $130.4 million related to net operating loss (NOL) carryforwards. CHI believes that most of the NOL carryforwards will expire unused, and has established a valuation allowance of $127.0 million against the deferred tax asset associated with these NOL carryforwards. Of the total deferred tax asset and valuation allowance at June 30, 2018, $62.7 million is related to discontinued operations.

Management reviews its tax positions annually and has determined that there are no material uncertain tax positions that require recognition in the accompanying consolidated financial statements.

1. Summary of Significant Accounting Policies (continued)

On December 22, 2017, the Tax Cuts and Jobs Act (the Tax Act) was enacted. The Tax Act reduces the U.S. federal corporate tax rate from 35% to 21%, requires companies to pay a one-time transition tax on earnings of certain foreign subsidiaries that were previously tax deferred, creates new taxes on certain foreign sourced earnings, provides for a new excise tax on certain compensation of exempt organizations over $1 million, and requires the separate calculation of unrelated business taxable income for each trade or business carried on.

At June 30, 2018, CHI has made provisional estimates of the tax effects of the Tax Act, including remeasuring its deferred tax balances at the new tax rate. CHI will continue to revise and refine its calculations as it receives additional guidance from the Internal Revenue Service on how the new provisions apply to exempt organizations and taxable subsidiaries.

Use of Estimates

The preparation of financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, revenues and expenses. Actual results could vary from the estimates.

New Accounting Pronouncements

Revenue Recognition – The Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2014-09, *Revenue from Contracts with Customers (Topic 606)*, and subsequent amendments thereto (collectively referred to herein as ASC 606), to clarify the principles for recognizing revenue and to improve financial reporting by creating common revenue recognition guidance for U.S. GAAP. 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.

ASC 606 is effective for annual reporting periods beginning after December 15, 2017, including interim periods within that reporting period.

CHI has evaluated the impact of adopting ASC 606 on its revenue recognition policies, procedures and control framework, and on its consolidated financial statements. Based on the work performed to-date, CHI has determined the adoption of ASC 606 will not have a material impact on its consolidated financial statements, with the exception of the new disclosure requirements. The most

1. Summary of Significant Accounting Policies (continued)

significant impact of adopting ASC 606 will be on the presentation of the provision for doubtful accounts on the consolidated statements of operations. After the adoption of ASC 606, the majority of what is currently separately presented as provision for doubtful accounts on the consolidated statements of operations will be considered an implicit price concession under the new guidance, and, therefore, included in patient services revenues in the consolidated statement of operations. CHI is in process of finalizing analyses of its various revenue streams and evaluating the presentation of fees paid to uncompensated care programs in the states in which it operates. CHI expects to adopt ASC 606 on July 1, 2018, using the modified retrospective approach.

Leases – The FASB issued ASU 2016-02, *Leases (Topic 842)*, and subsequent amendments thereto (collectively referred to herein as ASC 842), to require a lessee to recognize a right-of-use asset and a lease liability for both operating and finance leases, whereas previous U.S. GAAP required the asset and liability to be recognized only for capital leases. ASC 842 also modified the lease classification criteria for lessors, eliminates some of the real estate leasing guidance previously applied for certain leasing transactions, and requires qualitative and specific quantitative disclosures. ASC 842 is effective for fiscal years beginning after December 15, 2018, including interim periods within those fiscal years, with early adoption permitted. CHI anticipates adopting ASC 842 on July 1, 2019, and anticipates that because of the number of leases utilized by the organization, the adoption will have a significant impact on its consolidated financial statements. CHI is currently performing an assessment of the contractual provisions of its various leasing arrangements to determine a plan related to processes, systems and internal controls.

Presentation of Financial Statements of Not-for-Profit Entities – In August 2016, the FASB issued ASU 2016-14, *Not-for Profit Entities (Topic 958)*, to change the way a not-for-profit entity (NFP) classifies and presents net assets on the face of the financial statements, and presents information in the financial statements and notes about the NFP's liquidity, financial performance and cash flows. The amendment changes the way an NFP reports classes of net assets, from the currently required three classes to two, by eliminating the distinction between resources with permanent restrictions and those with temporary restrictions. The amendment also requires the NFP to provide enhanced disclosure about the nature, amounts and effects of the various types of donor-imposed restrictions, the NFP's management of its liquidity to meet short-term demands for cash, and the types of resources used and how they are allocated to carrying out the NFP's activities. ASU 2016-14 is effective for fiscal years beginning after December 15, 2017, and for interim periods within fiscal years beginning after December 15, 2018. Early application is permitted.

1. Summary of Significant Accounting Policies (continued)

Classification of Certain Cash Receipts and Cash Payments – In August 2016, the FASB issued ASU 2016-15, *Statement of Cash Flows (Topic 230)*, to provide guidance on the presentation and classification of eight specific cash flow issues, including debt prepayment or debt extinguishment costs, contingent consideration payments made after a business combination, proceeds from the settlement of insurance claims, distributions received from equity method investees, and separately identifiable cash flows and application of the predominance principle. The objective of the amendment is to reduce the existing diversity in practice. ASU 2016-15 is effective for fiscal years beginning after December 15, 2017, and interim periods within those fiscal years. Early adoption is permitted.

Restricted Cash – In November 2016, the FASB issued ASU 2016-18, *Statement of Cash Flows (Topic 230)*, to provide guidance on the presentation of restricted cash or restricted cash equivalents in the statement of cash flows. The amendments require that a statement of cash flows explain the change during the period in the total of cash, cash equivalents, and amounts generally described as restricted cash or restricted cash equivalents. ASU 2016-18 is effective for fiscal years beginning after December 15, 2017, and interim periods within those fiscal years. Early adoption is permitted.

Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost – In March 2017, the FASB issued ASU 2017-07, *Compensation – Retirement Benefits (Topic 715)*, to improve the presentation of net periodic pension cost and net periodic postretirement benefit cost. The amendments in this update require that an employer disaggregate the service cost component and the other components of net benefit cost, and that the service cost component be reflected in the same line item as other employee compensation costs. The other components of net benefit cost would be reported as nonoperating gains (losses) on the consolidated statement of operations. ASU 2017-07 is effective for annual periods beginning after December 15, 2018, and interim periods within annual periods beginning after December 15, 2019. Early adoption is permitted.

Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made – In June 2018, the FASB issued ASU 2018-08, *Not-for-Profit Entities (Topic 958)*, to clarify and improve current guidance about whether a transaction is a contribution or an exchange transaction, and whether a contribution is conditional. The amendments in the update clarify how an entity determines whether a resource provider is participating in an exchange transaction by evaluating whether the resource provider is receiving commensurate value in return for the resources transferred based on several criteria. ASU 2018-08 should be applied on a

1. Summary of Significant Accounting Policies (continued)

modified prospective basis, and is effective for contributions received in annual periods beginning after June 15, 2018, including interim periods within those annual periods. Early adoption is permitted.

Reclassifications

Certain reclassifications were made to the fiscal year 2017 consolidated financial statement presentation to conform to the 2018 presentation – effective July 1, 2017, CHI ceased consolidating the operations of University Medical Center (UMC). The results of operations of UMC for the previous fiscal year are no longer reported in the consolidated statement of operations, but are now reported as discontinued operations in the consolidated statements of changes in net assets. The assets and liabilities of UMC are reflected as assets and liabilities of discontinued operations on the consolidated balance sheets. See Note 5, *Assets and Liabilities of Discontinued Operations and Held for Sale*.

2. Community Benefit (Unaudited)

In accordance with its mission and philosophy, CHI commits substantial resources to sponsor a broad range of services to both the poor and the broader community. Community benefit provided to the poor includes the cost of providing services to persons who cannot afford health care due to inadequate resources and/or who are uninsured or underinsured. This type of community benefit includes the costs of traditional charity care; unpaid costs of care provided to beneficiaries of Medicaid and other indigent public programs; services such as free clinics and meal programs for which a patient is not billed or for which a nominal fee has been assessed; and cash and in-kind donations of equipment, supplies or staff time volunteered on behalf of the community.

Community benefit provided to the broader community includes the costs of providing services to other populations who may not qualify as poor but may need special services and support. This type of community benefit includes the costs of services such as health promotion and education, health clinics and screenings, all of which are not billed or can be operated only on a deficit basis; unpaid portions of training health professionals such as medical residents, nursing students and students in allied health professions; and the unpaid portions of testing medical equipment and controlled studies of therapeutic protocols.

2. Community Benefit (Unaudited) (continued)

A summary of the cost of community benefit provided to both the poor and the broader community is as follows for the years ended June 30 (in thousands):

	2018	2017
Cost of community benefit:		
Cost of charity care provided	**$ 226,169**	$ 240,837
Unpaid cost of public programs, Medicaid and other indigent care programs	**652,826**	611,131
Nonbilled services	**35,187**	28,450
Cash and in-kind donations	**6,429**	19,295
Education research	**72,596**	78,859
Other benefit	**78,561**	102,664
Total cost of community benefit from continuing operations	**1,071,768**	1,081,236
Total cost of community benefit from discontinued operations	**67,203**	132,594
Total cost of community benefit	**1,138,971**	1,213,830
Unpaid cost of Medicare from continuing operations	**924,794**	911,572
Total cost of community benefit and the unpaid cost of Medicare	**$ 2,063,765**	$ 2,125,402

The summary above has been prepared in accordance with the Catholic Health Association of the United States (CHA) publication, *A Guide for Planning & Reporting Community Benefit*. Community benefit is measured on the basis of total cost, net of any offsetting revenues, donations or other funds used to defray cost. During fiscal year 2018 and 2017, CHI received $22.1 million and $20.9 million, respectively, in funds used to subsidize charity care provided.

The total cost of community benefit from continuing and discontinued operations was 6.9% and 7.0% of total operating expenses before restructuring, impairment and other losses in fiscal years 2018 and 2017, respectively. The total cost of community benefit and the unpaid cost of Medicare from continuing and discontinued operations was 12.5% and 12.3% of total operating expenses before restructuring, impairment and other losses in fiscal years 2018 and 2017, respectively.

3. Joint Operating Agreements and Investments in Unconsolidated Organizations

Joint Operating Agreements

CHI participates in JOAs with hospital-based organizations in three separate market areas. The agreements generally provide for, among other things, joint management of the combined operations of the local facilities included in the JOAs through Joint Operating Companies (JOC). CHI retains ownership of the assets, liabilities, equity, revenues and expenses of the CHI facilities that participate in the JOAs. The financial statements of the CHI facilities managed under all JOAs are included in the CHI consolidated financial statements. Transfers of assets from facilities owned by the JOA participants generally are restricted under the terms of the agreements.

As of June 30, 2018 and 2017, CHI has investment interests of 65%, 50%, and 50% in JOCs based in Colorado, Iowa, and Ohio, respectively. CHI's interests in the JOCs are included in investments in unconsolidated organizations and totaled $435.8 million and $381.7 million at June 30, 2018 and 2017, respectively. CHI recognizes its investment in all JOCs under the equity method of accounting. The JOCs provide varying levels of services to the related JOA sponsors, and operating expenses of the JOCs are allocated to each sponsoring organization.

Investments in Unconsolidated Organizations

CHI holds noncontrolling interests in various other organizations, accounted for under the cost or equity method of accounting, as appropriate. Significant investments are described below.

Conifer Health Solutions (Conifer) – As of June 30, 2018 and 2017, CHI holds a 23.8% equity method investment in Conifer totaling $670.6 million and $614.0 million, respectively. The investment in Conifer was acquired as part of a multi-year agreement with Conifer where Conifer provides revenue cycle services and health information management solutions for CHI acute care operations. Since CHI was granted incremental shares in Conifer in conjunction with the multi-year agreement with Conifer, CHI also has a deferred income balance related to the Conifer agreement of $403.2 million and $431.1 million, as of June 30, 2018 and 2017, respectively, reported in other liabilities on the accompanying consolidated balance sheets. The deferred income balance is being amortized straight line over the remaining agreement term expiring in January 2033, offsetting revenue cycle services fees paid to Conifer, which are reported in purchased services expense in the accompanying consolidated statements of operations.

3. Joint Operating Agreements and Investments in Unconsolidated Organizations (continued)

As a result of CHI recording its incremental equity ownership in Conifer at fair value, the carrying value of its equity method investment in Conifer was $243.9 million and $253.3 million greater than CHI's equity interest in the underlying net assets of Conifer as of June 30, 2018 and 2017, respectively, due to basis differences in the carrying amounts of the tangible and intangible assets of $177.2 million and $186.6 million, respectively, and of goodwill of $66.7 million in both years. Goodwill is not amortized but is subject to annual impairment tests during the third quarter of the fiscal year, as well as more frequent reviews whenever circumstances indicate a possible impairment may exist. No impairment of goodwill was identified as of June 30, 2018 and 2017. The basis differences of the tangible and intangible assets are being amortized over the average useful lives of the underlying assets, ranging from 8 to 25 years, as a reduction of CHI's equity earnings in Conifer.

Premier Health Partners (Premier) – Effective on January 1, 2018, CHI entered into an agreement with Premier, an Ohio nonprofit corporation operating various hospitals in southwest Ohio, to reorganize and restructure the existing JOA with Premier. The agreement provided that CHI transfer ownership of the Good Samaritan-Dayton MBO to Premier in exchange for a 22% interest in Premier. No gain or loss was recognized upon the exchange as the net book value of the Good Samaritan-Dayton MBO was equal to the fair value of CHI's interest in Premier of $325.4 million. The fair value of CHI's interest in Premier was estimated based upon Level 3 inputs, including estimated future cash flows and probability-weighed performance assumptions. As of June 30, 2018, CHI's 22% equity method investment in Premier totals $310.8 million.

3. Joint Operating Agreements and Investments in Unconsolidated Organizations (continued)

The summarized financial positions and results of operations for all entities accounted for under the equity method of accounting as of and for the years ended June 30, are as follows (in thousands):

	2018						
	Outpatient and Diagnostic Services	Ambulatory Surgery Centers	JOC's and Related Hospital Services	Hospital Services	ACO/ CCO/ CIN	Other Investees	Total
Total assets	**$ 128,799**	**$ 81,815**	**$ 1,364,724**	**$ 2,937,914**	**$ 95,785**	**$ 1,536,081**	**$ 6,145,118**
Total debt	**16,451**	**8,545**	**68,150**	**949,411**	**–**	**45,285**	**1,087,842**
Net assets	**100,071**	**34,040**	**965,651**	**1,563,422**	**68,972**	**1,194,742**	**3,926,898**
Net patient services revenues	**107,080**	**99,054**	**794,449**	**1,036,066**	**–**	**220,217**	**2,256,866**
Total revenues, net	**158,156**	**123,153**	**926,822**	**1,072,584**	**147,323**	**702,445**	**3,130,483**
Excess (deficit) of revenues over expenses	**25,994**	**31,279**	**(127,089)**	**(37,794)**	**(6,395)**	**312,222**	**198,217**

	2017						
	Outpatient and Diagnostic Services	Ambulatory Surgery Centers	JOC's and Related Hospital Services	Hospital Services	ACO/ CCO/ CIN	Other Investees	Total
Total assets	$ 90,399	$ 82,079	$ 1,106,496	$ 185,356	$ 107,722	$ 1,319,303	$ 2,891,355
Total debt	5,976	21,480	75,302	17,343	–	89,700	209,801
Net assets	75,284	37,937	808,367	150,231	76,659	910,894	2,059,372
Net patient services revenues	84,779	96,056	763,904	177,431	–	201,054	1,323,224
Total revenues, net	137,557	125,565	884,180	177,889	180,436	629,238	2,134,865
Excess (deficit) of revenues over expenses	23,789	33,523	(93,825)	32,968	1,723	230,398	228,576

4. Acquisitions, Affiliations, and Divestitures

There were no significant business combinations and affiliations, individually or in the aggregate, during the fiscal year ended June 30, 2018.

During fiscal year 2017, CHI entered into various business combinations and affiliations, including the acquisition by a subsidiary of CHI of the operations of a multi-specialty group in the state of Texas. The operations include a general acute care hospital and emergency room, an ambulatory surgery center, a management company, and an independent physician association comprising of more than 80 health care providers. The fair value of identifiable assets acquired and liabilities assumed were determined based upon Level 3 inputs, including estimated future cash flows and

4. Acquisitions, Affiliations, and Divestitures (continued)

probability-weighted performance assumptions. The following table is a summary of significant business combinations and affiliations that occurred during the fiscal year ended June 30, 2017 (in thousands):

Fiscal year 2017		
Purchase consideration:		
Cash	$	64,432
Current liabilities		723
Debt		27,755
	$	92,910
Purchase price allocation:		
Inventory	$	3,041
Property and equipment		39,681
Intangible assets		11,180
Goodwill		43,865
Current liabilities		(752)
Debt		(4,105)
	$	92,910

The affiliations and acquisitions reported a combined $49.9 million and $52.0 million, respectively, in operating revenues, and $(26.3) million and $(17.5) million, respectively, in deficit of revenues over expenses to the CHI consolidated results of operations for the fiscal years ended June 30, 2018 and 2017, respectively.

Other Affiliations

Pathology Associates Medical Laboratories, LLC (PAML) – Effective in May 2017, CHI sold all of its interests in PAML to Laboratory Corporation of America Holdings (LabCorp). As part of the agreement, LabCorp also acquired CHI's direct and indirect interests in three CHI joint ventures with PAML in the states of Colorado, Kentucky and Washington. Nonrefundable gross sales proceeds attributable to CHI and its affiliates of $96.7 million were received in May 2017, resulting in a gain on sale of $40.2 million reflected in other operating revenues in the consolidated statements of operations.

4. Acquisitions, Affiliations, and Divestitures (continued)

KentuckyOne Health Noncontrolling Interest – Effective September 1, 2017, CHI became the sole owner of KentuckyOne Health through the purchase of the noncontrolling interest from the remaining partner for $150.0 million in cash consideration.

Dignity Health – On December 7, 2017, CHI and Dignity Health signed a definitive agreement to combine their ministries. The combined ministries will build a stronger operational and financial foundation to expand access to quality care, build upon complementary resources and capabilities, and reinvest in critical areas to accelerate improvements in care delivery across 28 states.

The combined ministries will include more than 700 care sites and 139 hospitals, offering people and communities access to quality care delivered by approximately 159,000 employees and more than 25,000 physicians and other advanced practice clinicians. The ministries are geographically complementary with no overlap across hospital service areas.

The agreement is anticipated to close in the second half of calendar year 2018, subject to federal and state approvals.

5. Assets and Liabilities of Discontinued Operations and Held for Sale

Assets and liabilities of discontinued operations and held for sale represent the operations of UMC, JHSMH, and QualChoice Health, Inc. (QualChoice Health). The assets and liabilities of JHSMH and QualChoice Health are reflected as held for sale, in accordance with Accounting Standards Codification (ASC) 205-20, *Presentation of Financial Statements – Discontinued Operations.*

UMC deconsolidation – Effective on July 1, 2017, and in accordance with the agreement entered into in December 2016 between KentuckyOne Health and UMC, UMC took over the management of its assets and CHI ceased consolidating the UMC operations. The transaction resulted in a loss on deconsolidation of $319.2 million (equal to the net assets of UMC as of June 30, 2017) for the fiscal year ended June 30, 2018, reflected in discontinued operations in the accompanying consolidated statement of changes in net assets. The assets and liabilities of UMC for the prior fiscal year were also reclassified and reflected as assets and liabilities of discontinued operations on the consolidated balance sheet.

5. Assets and Liabilities of Discontinued Operations and Held for Sale (continued)

JHSMH held for sale – In May 2017, CHI approved a plan to sell or otherwise dispose of certain entities of JHSMH. In December 2017, CHI entered into a nonbinding letter of intent to negotiate a definitive agreement for the purchase of substantially all of the JHSMH assets. As of December 31, 2017, and as a result of the anticipated sale transaction, the assets and liabilities of the JHSMH discontinued operations were remeasured at the lower of their carrying amount or their fair value less cost to sell, which resulted in the recognition of an impairment charge of $272.0 million in the consolidated statement of changes in net assets.

In June 2018, an updated letter of intent for the purchase of JHSMH was received, and based upon the terms of that letter of intent, CHI recognized additional impairment charges of $105.5 million in discontinued operations and $11.8 million in continuing operations, to adjust the JHSMH property and equipment values to the lower of their carrying value or their fair value less cost to sell. CHI anticipates closing on a sale during fiscal year 2019.

QualChoice Health held for sale – In September 2018, CHI entered into an asset purchase agreement for the sale of its Medicare Advantage health insurance operations in the state of Washington, effective in January 2019. The purchase price is contingent upon future increases in the number of lives covered by the Medicare Advantage plans acquired, and upon maintaining a specified Centers for Medicare & Medicaid Services (CMS) Star Rating as published annually in October 2018 and 2019.

In May 2018, CHI also entered into a letter of intent for the sale of its commercial insurance operations. Negotiations are currently under way, and CHI anticipates closing on the sale during fiscal year 2019.

5. Assets and Liabilities of Discontinued Operations and Held for Sale (continued)

A reconciliation of major classes of assets and liabilities of the discontinued operations held for sale is presented below as of June 30 (in thousands):

	2018	2017		
	Held for Sale	**Held for Sale**	**UMC**	**Total**
Cash	**$ –**	$ –	$ 222,931	$ 222,931
Accounts receivable	**–**	–	90,198	90,198
Other accounts receivable	**23,672**	31,204	1,788	32,992
Investments held for insurance purposes	**126,899**	132,519	28,450	160,969
Property and equipment, net	**6,918**	380,495	191,153	571,648
Intangibles	**–**	–	53,178	53,178
Other assets	**31,320**	35,725	17,769	53,494
Total major classes of assets of the discontinued operations	**188,809**	579,943	605,467	1,185,410
Other assets classified as held for sale	**6,889**	2,401	–	2,401
Total assets classified as discontinued operations and held for sale	**$ 195,698**	$ 582,344	$ 605,467	$ 1,187,811
Compensation and benefits	**$ 42,167**	$ 48,530	$ 9,766	$ 58,296
Accounts payable and accrued expenses	**66,260**	50,297	127,993	178,290
Debt	**8,856**	10,258	62,241	72,499
Self-insured reserves	**91,094**	62,049	2,388	64,437
Other liabilities	**36,918**	42,317	76,601	118,918
Total major classes of liabilities of the discontinued operations	**245,295**	213,451	278,989	492,440
Other liabilities classified as held for sale	**6,415**	–	–	–
Total liabilities classified as discontinued operations and held for sale	**$ 251,710**	$ 213,451	$ 278,989	$ 492,440

The $6.9 million and $2.4 million of other assets classified as held for sale as of June 30, 2018 and 2017, respectively, represent real estate and other assets that are scheduled to be sold in fiscal year 2019, measured at the lower of their carrying amount or fair value less cost to sell.

5. Assets and Liabilities of Discontinued Operations and Held for Sale (continued)

Operating results of discontinued operations are reported in the accompanying consolidated statements of changes in net assets and are summarized as follows for the years ended June 30 (in thousands):

	2018	2017
Net patient service revenues	**$ 713,441**	$ 1,251,108
Other operating revenues	**582,047**	618,287
Total operating revenues	**1,295,488**	1,869,395
Salaries, wages and employee benefits	**440,097**	657,664
Purchased services and medical claims	**625,092**	748,556
Depreciation and amortization	**3,516**	64,818
Other expenses	**291,486**	515,359
Total operating expenses before restructuring, impairment and other losses	**1,360,191**	1,986,397
Loss from operations before restructuring, impairment and other losses	**(64,703)**	(117,002)
Restructuring, impairment and other losses	**(724,198)**	(25,517)
Loss from operations	**(788,901)**	(142,519)
Nonoperating (losses) gains	**(4,853)**	7,719
Deficit of revenues over expenses	**(793,754)**	(134,800)
Deficit of revenues over expenses attributable to noncontrolling interest	**(3,261)**	(18,500)
Deficit of revenues over expenses attributable to CHI	**$ (790,493)**	$ (116,300)

For the fiscal year ended June 30, 2018, discontinued operations include JHSMH impairment charges totaling $377.5 million and the $319.2 million loss on deconsolidation of UMC.

The discontinued operations reported $7.5 million and $36.3 million in capital expenditures for fiscal years 2018 and 2017, respectively.

6. Net Patient Services Revenues

Net patient services revenues are derived from services provided to patients who are either directly responsible for payment or are covered by various insurance or managed care programs. CHI receives payments from the federal government on behalf of patients covered by the Medicare program, from state governments for Medicaid and other state-sponsored programs, from certain private insurance companies and managed care programs, and from patients themselves. A summary of payment arrangements with major third-party payors follows:

Medicare – Inpatient acute care and certain outpatient services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge or procedure. These rates vary according to patient classification systems based on clinical, diagnostic and other factors. Certain CHI facilities have been designated as critical access hospitals and, accordingly, are reimbursed their cost of providing services to Medicare beneficiaries. Professional services rendered by physicians are paid based on the Medicare allowable fee schedule.

Medicaid – Inpatient services rendered to Medicaid program beneficiaries are primarily paid under the traditional Medicaid plan at prospectively determined rates per discharge. Certain outpatient services are reimbursed based on a cost reimbursement methodology, fee schedules or discounts from established charges.

Other – CHI has also entered into payment agreements with certain managed care and commercial insurance carriers, health maintenance organizations and preferred provider organizations. The basis for payment to CHI under these agreements includes prospectively determined rates per discharge, discounts from established charges and prospectively determined daily rates.

CHI's Medicare, Medicaid and other payor utilization percentages, based upon net patient services revenues before provision for doubtful accounts, are as follows for the years ended June 30:

	2018	**2017**
Medicare	**36%**	36%
Medicaid	**12**	14
Managed care	**40**	39
Self-pay	**3**	3
Commercial and other	**9**	8
	100%	100%

6. Net Patient Services Revenues (continued)

Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Estimated settlements related to Medicare and Medicaid of $110.4 million and $90.2 million at June 30, 2018 and 2017, respectively, are included in third-party liabilities. Net patient services revenues from continuing operations increased by $47.6 million and $68.9 million in fiscal years 2018 and 2017, respectively, due to favorable changes in estimates related to prior-year settlements.

7. Investments and Assets Limited as to Use

CHI's investments and assets limited as to use are reported in the accompanying consolidated balance sheets as presented in the following table (in thousands):

	June 30	
	2018	**2017**
Cash and equivalents	**$ 106,053**	$ 150,960
CHI Investment Program	**5,534,127**	5,703,077
Marketable equity securities	**267,390**	274,671
Marketable fixed-income securities	**623,789**	664,155
Hedge funds and other investments	**5,852**	30,319
	6,537,211	6,823,182
Less current portion	**(64,348)**	(65,161)
	$ 6,472,863	$ 6,758,021

CHI attempts to reduce its market risk by diversifying its investment portfolio using cash equivalents, fixed-income securities, marketable equity securities and alternative investments. Most of the U.S. Treasury, money market funds and corporate debt obligations as well as exchange-traded marketable securities held directly by CHI and by the CHI Investment Program (the Program) have an actively traded market. However, CHI also invests in commercial paper, mortgage-backed or other asset-backed securities, alternative investments (hedge funds, private equity investments, real estate funds, funds of funds, etc.), collateralized debt obligations, municipal securities and other investments that have potential complexities in valuation based upon the current conditions in the credit markets. For some of these instruments, evidence supporting the determination of fair value may not come from trading in active primary or secondary markets. Because these investments may not be readily marketable, the estimated value

7. Investments and Assets Limited as to Use (continued)

is subject to uncertainty and, therefore, may differ from the value that would have been used had an active market for such investments existed. Such differences could be material. However, management reviews the CHI investment portfolio on a regular basis and seeks guidance from its professional portfolio managers related to U.S. and global market conditions to determine the fair value of its investments. CHI believes the carrying amount of these financial instruments in the accompanying consolidated financial statements is a reasonable estimate of fair value.

The majority of all CHI long-term investments are held in the Program. The Program is structured under a Limited Partnership Agreement with CHI as managing general partner and numerous limited partners, most sponsored by CHI. The partnership provides a vehicle whereby virtually all entities associated with CHI, as well as certain other unrelated entities, can optimize investment returns while managing investment risk. Entities participating in the Program that are not consolidated in the accompanying financial statements have the ability to direct their invested amounts and liquidate and/or withdraw their interest without penalty as soon as practicable based on market conditions but within 180 days of notification. The Limited Partnership Agreement permits a simple-majority vote of the noncontrolling limited partners to terminate the partnership. Accordingly, CHI recognizes only the unitized portion of Program assets attributable to CHI and its direct affiliates. Program assets attributable to CHI and its Direct Affiliates represented 89% of total Program assets at June 30, 2018 and 2017, respectively.

The Program asset allocation is as follows:

	June 30	
	2018	**2017**
Equity securities	**43%**	41%
Fixed-income securities	**36**	39
Alternative investments	**20**	19
Cash and equivalents	**1**	1
	100%	100%

The CHI Finance Committee (the Committee) of the Board of Stewardship Trustees is responsible for determining target asset allocations among fixed-income, equity, and alternative investments. At least annually, the Committee reviews targeted allocations and, if necessary, makes adjustments to targeted asset allocations. Given the diversity of the underlying securities in which the Program invests, management does not believe there is a significant concentration of credit risk.

7. Investments and Assets Limited as to Use (continued)

The Program allocation to alternative investments is based upon contractual commitment levels to various funds. These commitments are drawn by the fund managers as opportunities arise to invest the capital. As of June 30, 2018, the Program had committed to invest $1.0 billion in 45 funds, of which $839.9 million had been invested. The remaining $164.2 million will be invested when and if, requested by the funds. Alternative investments within the Program have limited liquidity. As of June 30, 2018, illiquid investments not available for redemption totaled $395.0 million, and investments available for redemption within 180 days at the request of the Program totaled $858.5 million.

Investment income, net is comprised of the following for the years ended June 30 (in thousands):

	2018	2017
Dividend and interest income	**$ 144,050**	$ 143,072
Net realized gains	**286,715**	334,059
Net unrealized gains	**11,731**	152,085
Investment income, net from continuing operations	**442,496**	629,216
Investment (losses) income, net from discontinued operations	**(4,853)**	7,719
Total investment income, net	**$ 437,643**	$ 636,935

Direct expenses of the Program attributable to CHI and its Direct Affiliates were approximately $18.5 million and $17.0 million for the years ended June 30, 2018 and 2017, respectively, and are reflected in investment income. Fees paid to certain alternative investment managers are not included in the Program's total expense calculation as they are not a direct expense of the Program, but the fees are deducted from the alternative investment's performance and reflected in investment income.

8. Fair Value of Assets and Liabilities

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. ASC 820, *Fair Value Measurements and Disclosures*, establishes a fair value hierarchy that prioritizes the inputs 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 inputs) and the lowest priority to unobservable inputs (Level 3 inputs).

8. Fair Value of Assets and Liabilities (continued)

The three levels of the fair value hierarchy and a description of the valuation methodologies used for instruments measured at fair value are as follows:

Level 1 – Valuation is based upon quoted prices (unadjusted) for identical assets or liabilities in active markets.

Level 2 – Valuation is based upon quoted prices for similar assets and liabilities in active markets or other inputs that are observable for the asset or liability, either directly or indirectly, for substantially the full term of the financial asset or liability.

Level 3 – Valuation is based upon other unobservable inputs that are significant to the fair value measurement.

Certain of CHI's alternative investments are made through limited liability companies (LLC) and limited liability partnerships (LLP). These LLCs and LLPs provide CHI with a proportionate share of the investment gains (losses). CHI accounts for its ownership in the LLCs and LLPs under the equity method. CHI also accounts for its ownership in the Program under the equity method. As such, these investments are excluded from the scope of ASC 820.

8. Fair Value of Assets and Liabilities (continued)

Financial assets and liabilities measured at fair value on a recurring basis were determined using the market approach based upon the following inputs (in thousands):

	June 30, 2018			
	Fair Value Measurements at Reporting Date Using			
		(Level 1)	(Level 2)	(Level 3)
	Total	Quoted Prices in Active Markets	Other Observable Inputs	Unobservable Inputs
Assets				
Assets limited as to use:				
Cash and short-term investments	**$ 106,053**	**$ 96,316**	**$ 9,737**	**$ –**
Equity securities	**267,390**	**267,390**	**–**	**–**
Fixed-income securities	**623,789**	**185,307**	**438,482**	**–**
Other investments	**2,585**	**–**	**–**	**2,585**
Deferred compensation assets:				
Cash and short-term investments	**5,249**	**5,249**	**–**	**–**
	$1,005,066	**$ 554,262**	**$ 448,219**	**$ 2,585**
Liabilities				
Interest rate swaps	**$ 208,462**	**$ –**	**$ 208,462**	**$ –**
Contingent consideration	**80,891**	**–**	**–**	**80,891**
Deferred compensation liability	**5,249**	**5,249**	**–**	**–**
	$ 294,602	**$ 5,249**	**$ 208,462**	**$ 80,891**

8. Fair Value of Assets and Liabilities (continued)

	June 30, 2017			
	Fair Value Measurements at Reporting Date Using			
		(Level 1)	(Level 2)	(Level 3)
	Total	Quoted Prices in Active Markets	Other Observable Inputs	Unobservable Inputs
Assets				
Assets limited as to use:				
Cash and short-term investments	$ 150,960	$ 130,400	$ 20,560	$ –
Equity securities	274,671	274,671	–	–
Fixed-income securities	664,155	170,425	493,730	–
Other investments	3,523	–	–	3,523
Deferred compensation assets:				
Cash and short-term investments	6,708	6,708	–	–
	$ 1,100,017	$ 582,204	$ 514,290	$ 3,523
Liabilities				
Interest rate swaps	$ 287,990	$ –	$ 287,990	$ –
Contingent consideration	87,959	–	–	87,959
Deferred compensation liability	6,708	6,708	–	–
	$ 382,657	$ 6,708	$ 287,990	$ 87,959

The fair values of the securities included in Level 1 were determined through quoted market prices. Level 1 instruments include money market funds, mutual funds, and marketable debt and equity securities. The fair values of Level 2 instruments were determined through evaluated bid prices based on recent trading activity and other relevant information, including market interest rate curves and referenced credit spreads; estimated prepayment rates, where applicable, are used for valuation purposes and are provided by third-party services where quoted market values are not available. Level 2 instruments include corporate fixed-income securities, government bonds, mortgage and asset-backed securities, and interest rate swaps. The fair values of Level 3 securities are determined primarily through information obtained from the relevant counterparties for such investments. Information on which these securities' fair values are based is generally not readily available in the market. The fair value of the contingent consideration liability was determined based on estimated future cash flows and probability-weighted performance assumptions, discounted to net present value. The contingent consideration liability balance was adjusted to reflect $9.0 million of payments made since June 30, 2017, and to reflect a $1.9 million increase for accretion and changes in payment assumptions, reported in other expenses in the accompanying consolidated statements of operations.

9. Property and Equipment

A summary of property, equipment, and software is as follows as of June 30 (in thousands):

	2018	2017
Land and improvements	**$ 758,732**	$ 778,652
Buildings and improvements	**7,162,024**	7,092,734
Equipment	**5,837,619**	5,552,473
Software	**1,107,182**	1,113,667
	14,865,557	14,537,526
Less accumulated depreciation and amortization	**(7,410,941)**	(7,042,719)
	7,454,616	7,494,807
Construction in progress	**656,151**	883,354
	$ 8,110,767	$ 8,378,161

CHI incurs a variety of direct and indirect costs to develop internal-use software. In order for software to be considered internal use, it must be acquired, internally developed or modified solely to meet CHI's needs, and no plan exists or is being developed to sell the software externally during the software's development or modification. Unamortized software costs as of June 30, 2018 and 2017, were $622.9 million and $746.3 million, respectively. For the fiscal years ended June 30, 2018 and 2017, CHI recorded $141.8 million and $137.8 million, respectively, related to amortization of internal-use software. Amortization of internal-use software begins when the software is placed in service, and is based on the expected useful life of the software, which is generally between 2 and 10 years.

During fiscal year 2017, CHI sold various real estate assets across the enterprise as part of a long-term effort to improve the mix of owned and leased assets. In conjunction with the sale, CHI entered into 10-year operating lease agreements with the buyers, and in accordance with ASC 840-40, *Leases – Sale-Lease Back Transactions*, certain of the gains on the sale of the real estate assets were deferred and will be amortized to lease expense over the life of the operating leases.

9. Property and Equipment (continued)

In fiscal year 2017, real estate assets with a net book value of $281.8 million were sold for gross proceeds of $366.5 million, and CHI recognized $22.0 million gains on sales, reflected in other operating revenues in the consolidated statements of operations for the year ended June 30, 2017. CHI also recorded short-term deferred gains of $5.8 million and long-term deferred gains of $52.2 million for fiscal year 2017. On the consolidated balance sheet, the short-term deferred gains are a component of accrued expenses, and the long-term deferred gains are a component of other long-term liabilities. The deferred gains will be amortized against rent expense over the terms of the respective operating lease agreements.

CHI also sold various other assets during fiscal year 2017 for net proceeds of $101.7 million, reflected within other operating revenues as gain on sale on the consolidated statement of operations for the year ended June 30, 2017.

10. Debt Obligations

The following is a summary of debt obligations (in thousands):

	June 30	
	2018	**2017**
Debt secured under the CHI COD		
Fixed-rate debt:		
Fixed-rate serial and term exempt bonds payable in installments from 2018 through 2045; interest at 2.84% to 7.0%	**$ 2,784,522**	$ 2,853,602
Fixed-rate serial and term taxable bonds payable in installments from 2018 through 2042; interest at 2.6% to 4.35%	**1,790,000**	2,040,000
Long-term rate exempt bonds subject to mandatory tender from 2019 through 2021; interest at 1.88% to 5.0%	**141,870**	141,870
Total fixed-rate debt	**4,716,392**	5,035,472
Variable-rate debt:		
Floating rate notes subject to mandatory tender from 2020 through 2025; interest set at prevailing market rates (2.25% to 2.91% at June 30, 2018)	**411,145**	411,145
Variable-rate demand bonds subject to optional 7-day tender terms and mandatory tender from 2032 through 2035; interest set at prevailing market rates (1.58% to 1.63% at June 30, 2018)	**96,700**	96,700
Variable-rate direct purchase exempt bonds subject to mandatory tender from 2018 through 2024; interest set at prevailing market rates (2.38% to 3.81% at June 30, 2018)	**928,287**	601,982
Variable-rate direct purchase taxable bonds subject to mandatory tender from 2018 through 2020; interest set at prevailing market rates (3.35% to 4.73% at June 30, 2018)	**650,000**	400,000
Bank line of credit maturing July 2018; interest set at prevailing market rates (2.86% at June 30, 2018)	**250,000**	250,000
Bank loan	**–**	333,741
Commercial paper notes with maturities ranging 3 to 128 days from June 30, 2018; interest set at prevailing market rates (2.74% at June 30, 2018)	**881,000**	815,519
Total variable-rate debt	**3,217,132**	2,909,087
Total debt secured under the CHI COD	**7,933,524**	7,944,559
St. Leonard Master Trust Indenture fixed-rate exempt bonds payable in installments through 2040; interest at 6.0% to 6.63%	**39,707**	40,732
Other debt:		
Capital lease obligations	**112,889**	106,400
Note payable issued to Episcopal Health Foundation payable in installments through 2020; interest at 4.0%	**98,726**	133,560
Other notes payable and debt obligations	**345,467**	418,697
Total debt obligations before unamortized debt issuance costs, debt premium and debt discount, net	**8,530,313**	8,643,948
Unamortized debt issuance costs, debt premium and debt discount, net	**(4,276)**	(3,780)
Total debt obligations	**8,526,037**	8,640,168
Less: amounts classified as current:		
Variable-rate debt with self-liquidity	**(96,700)**	(96,700)
Commercial paper and current portion of debt	**(2,087,406)**	(2,016,042)
Long-term debt	**$ 6,341,931**	$ 6,527,426

10. Debt Obligations (continued)

The fair value of debt obligations was approximately $8.6 billion at June 30, 2018. Management has determined the carrying values of the variable-rate bonds are representative of fair values as of June 30, 2018, as the interest rates are set by the market participants. The fair value of the fixed-rate tax-exempt bond obligations is determined by applying credit spreads for similar tax-exempt obligations in the marketplace, which are then used to calculate a price/yield for the outstanding obligations (Level 2 inputs).

A summary of scheduled principal payments, based upon stated maturities, on debt obligations for the next five years is as follows (in thousands):

	Amounts Due
Year Ending June 30:	
2019	$ 2,184,106
2020	423,070
2021	170,646
2022	220,087
2023	612,327

CHI issues the majority of its debt under the COD and is the sole obligor. Bondholder security resides both in the unsecured promise by CHI to pay its obligations and in its control of its Direct and Designated Affiliates. Covenants include a minimum CHI debt service coverage ratio, a minimum amount of days cash on hand and certain limitations on secured debt. The Direct Affiliates of CHI, defined as Participants under the COD, have agreed to certain covenants related to corporate existence, maintenance of insurance and exempt use of bond-financed facilities.

Debt issued under the St. Leonard Master Trust Indenture is secured by the property of St. Leonard in Centerville, Ohio, and a pledge of gross revenues.

Debt Redemptions and Reissuances

In August 2016, CHI redeemed $62.0 million of Series 2012A fixed-rate bonds in connection with the sale in the prior fiscal year of the underlying real estate assets. The bond redemption was funded from the real estate sale proceeds and resulted in a loss on redemption of $8.5 million included in losses on early extinguishment of debt in the accompanying consolidated statement of operations.

10. Debt Obligations (continued)

In August 2017, CHI redeemed $34.5 million of bonds originally acquired in fiscal year 2016 as part of the acquisition of Trinity Health System. The bond redemption was funded from cash and investments, resulting in a gain on redemption of $0.2 million reflected in the accompanying consolidated statements of operations.

In October 2017, CHI issued $250.0 million of Series 2017A variable-rate direct purchase taxable bonds subject to mandatory tender in October 2018. Proceeds were used to pay the $250.0 million principal payment due on Series 2012 fixed-rate taxable bonds.

In December 2017, CHI issued $333.7 million of Series 2017B fixed-rate direct purchase exempt bonds subject to mandatory tender in December 2018. Proceeds were used to pay the $333.7 million bank loan that matured in December 2017.

In March 2018, CHI issued $65.5 million in commercial paper notes. Proceeds were used to pay $34.8 million in principal payments, and for general purposes and capital improvements.

In July 2018, CHI issued $275.0 million of Series 2018A taxable bonds subject to mandatory tender in August 2021. Proceeds were used to fund the $275.0 million Series 2013D taxable bonds principal payment due in August 2018. Also in July 2018, CHI extended the mandatory purchase date of $250.0 million of the 2017A taxable bonds from August 2018 to July 2021. As a result, CHI classified the Series 2013D and 2017A taxable bonds as long-term debt as of June 30, 2018.

Liquidity Facilities, Credit Facilities, and Lines of Credit

CHI has external liquidity facilities available totaling $365.0 million at June 30, 2018 and 2017, which can be used to support CHI's obligations to fund tenders of variable rate demand bonds and to pay maturing principal of commercial paper.

At June 30, 2018 and 2017, CHI classified as current $881.0 million and $815.5 million, respectively, of commercial paper due to maturities of less than one year, and $96.7 million of VRDBs due to the holder's ability to put such VRDBs back to CHI on a daily basis, after providing a seven-day notice to tender.

10. Debt Obligations (continued)

At June 30, 2018 and 2017, CHI had a credit facility with a third-party bank totaling $69.0 million, of which letters of credit totaling $59.5 million and $63.8 million at June 30, 2018 and 2017, respectively, have been designated for the benefit of third parties, principally in support of the self-insurance programs administered by FIIL. No amounts were outstanding under this credit facility at June 30, 2018 and 2017.

At June 30, 2018 and 2017, CHI had a $250.0 million bank line of credit, which was fully drawn. The line of credit matured in July 2017, and was funded by the issuance of a new $250.0 million line of credit with another third-party bank. The new line of credit, as amended, matures in July 2019, and is classified as current portion of debt in the accompanying consolidated balance sheets.

Interest Rate Swap Agreements

CHI utilizes various interest rate swap contracts to manage the risk of increased interest rates payable of certain variable-rate bonds. The fixed-payer swap agreements convert CHI's variable-rate debt to fixed-rate debt. Generally, it is CHI's policy that all counterparties have an AA rating or better. The swap agreements generally require CHI to provide collateral if CHI's liability, determined on a mark-to-market basis, exceeds a specified threshold that varies based upon the rating on CHI's long-term indebtedness.

The fair value of the swaps is estimated based on the present value sum of anticipated future net cash settlements until the swaps' maturities. Cash collateral balances are netted against the fair value of the swaps, and the net amount is reflected in other liabilities in the accompanying consolidated balance sheets. At June 30, 2018 and 2017, the swap liability reflected in other liabilities was $33.6 million and $28.9 million, respectively, net of swap collateral posted of $174.9 million and $259.1 million, respectively. The change in the fair value of swap agreements resulted in a net gain of $79.6 million and $127.9 million for the years ended June 30, 2018 and 2017, respectively, and is reflected in realized and unrealized losses on interest rate swaps in the accompanying consolidated statements of operations.

Based upon the swap agreements in place as of June 30, 2018, a reduction in CHI's credit rating to BBB would obligate CHI to post additional cash collateral of $29.0 million. If CHI's credit rating were to fall below BBB, the swap counterparties would have the option to require CHI to settle the swap liabilities at the recorded fair value, which was $33.6 million as of June 30, 2018.

10. Debt Obligations (continued)

Following is a summary of interest rate swap contracts (in thousands):

	Maturity Date	Swap Contracts Outstanding June 30, 2018	Swap Contracts Outstanding June 30, 2017	Fair Value Liability (Asset) June 30, 2018	Fair Value Liability (Asset) June 30, 2017	Notional Amount June 30, 2018	Notional Amount June 30, 2017
Basis swaps	3/2028	**1**	1	**$ (474)**	$ (374)	**$ 30,000**	$ 30,000
Fixed payer swaps	2024–2047	**15**	15	**207,446**	286,882	**1,373,096**	1,411,223
Total return swaps	2018–2020	**19**	25	**1,490**	1,482	**154,462**	174,777
		35	41	**$ 208,462**	$ 287,990	**$ 1,557,558**	$ 1,616,000

11. Retirement Plans

CHI Pension Plan

CHI and its direct affiliates maintain a variety of noncontributory, defined benefit retirement plans (Retirement Plans) for their employees. Certain of these plans were frozen in previous fiscal years, and benefits earned by employees through that time period remain in the Retirement Plans, where employees continue to receive interest credits and vesting credits, if applicable. Benefits in the Retirement Plans are based on compensation, retirement age, and years of service. Substantially all of the Retirement Plans are qualified as church plans and are exempt from certain provisions of both the Employee Retirement Income Security Act of 1974 and Pension Benefit Guaranty Corporation premiums and coverage. Funding requirements are determined through consultation with independent actuaries.

CHI recognizes the funded status (that is, the difference between the fair value of plan assets and the projected benefit obligations) of its Retirement Plans in the consolidated balance sheets, with a corresponding adjustment to net assets. Actuarial gains and losses that arise and are not recognized as net periodic pension cost in the same periods are recognized as a component of changes in net assets.

11. Retirement Plans (continued)

A summary of the changes in the benefit obligation, fair value of plan assets and funded status of the Retirement Plans at the June 30 measurement dates is as follows (in thousands):

	2018	2017
Change in benefit obligation:		
Benefit obligation, beginning of year	**$ 5,178,365**	$ 5,431,434
Service cost	**13,785**	9,340
Interest cost	**164,290**	152,067
Actuarial gain	**(39,819)**	(146,604)
Plan amendments	**(13,716)**	–
Settlements	**(216,885)**	(162,860)
Benefits paid	**(123,911)**	(103,315)
Expenses paid	**(1,876)**	(1,697)
Benefit obligation, end of year	**4,960,233**	5,178,365
Change in the Retirement Plans' assets:		
Fair value of the Retirement Plans' assets, beginning of year	**4,067,382**	3,895,594
Actual return on the Retirement Plans' assets, net of expenses	**272,471**	360,147
Employer contributions	**108,625**	79,513
Settlements	**(216,885)**	(162,860)
Benefits paid	**(123,911)**	(103,315)
Expenses paid	**(1,876)**	(1,697)
Fair value of the Retirement Plans' assets, end of year	**4,105,806**	4,067,382
Funded status of the Retirement Plans	**$ (854,427)**	$ (1,110,983)
End-of-year values:		
Projected benefit obligation	**$ 4,960,233**	$ 5,178,365
Accumulated benefit obligation	**4,956,393**	5,170,046

Included in unrestricted net assets at June 30, 2018, are unrecognized actuarial losses of $1.2 billion that have not yet been recognized in net periodic pension cost. The actuarial losses included in unrestricted net assets and expected to be recognized in net periodic pension cost during the fiscal year ending June 30, 2019, total $45.5 million.

11. Retirement Plans (continued)

The components of net periodic pension expense (income) for the years ended June 30 are as follows (in thousands):

	2018	2017
Components of net periodic pension expense (income):		
Service cost	**$ 13,785**	$ 9,340
Interest cost	**164,290**	152,067
Expected return on the Retirement Plans' assets	**(283,508)**	(271,545)
Actuarial losses	**46,370**	60,182
Settlements	**54,696**	40,608
	$ (4,367)	$ (9,348)

The service cost, interest cost, expected return on the Retirement Plans' assets, actuarial losses, and amortization of prior service benefit components of net periodic pension expense (income) are recognized in the consolidated statements of operations within employee benefits expense. The settlements component of net periodic pension expense (income) is recognized in the consolidated statements of operations within restructuring, impairment and other losses.

During fiscal years 2018 and 2017, certain Retirement Plans triggered settlement accounting, which occurs when lump-sum distributions exceed the sum of service and interest costs. This acceleration of benefit payments resulted in the remeasurement of the Retirement Plans' benefit obligation and the recognition in the consolidated statements of operations, within restructuring, impairment and other losses, of a portion of unrecognized actuarial losses previously recognized within net assets in the consolidated balance sheet, as disclosed above.

The assumption for the expected return on the Retirement Plans' assets is based on historical returns and adherence to the asset allocations set forth in the Retirement Plans' investment policies.

Weighted-average assumptions used to determine the pension benefit obligation for the years ended June 30 are as follows:

	2018	2017
Discount rate	**4.13%–4.27%**	3.71%–3.95%
Rate of compensation increase	**n/a**	n/a

11. Retirement Plans (continued)

The increase in the discount rate at June 30, 2018, decreased the pension benefit obligation by approximately $230.0 million.

Weighted-average assumptions used to determine the net periodic pension expense (income) for the years ended June 30 are as follows:

	2018	**2017**
Discount rate	**3.67%–4.18%**	3.52%–3.82%
Expected return on Retirement Plans' assets	**5.50%–7.20%**	5.50%–7.20%
Rate of compensation increase	**n/a**	n/a

CHI expects to contribute $87.1 million to the Retirement Plans in fiscal year 2019. A summary of expected benefits to be paid to the Retirement Plans' participants and beneficiaries is as follows (in thousands):

	Estimated Payments
Year Ending June 30:	
2019	$ 374,662
2020	302,954
2021	305,420
2022	308,698
2023	314,534
2024–2028	1,546,823

11. Retirement Plans (continued)

A summary of the Retirement Plans' assets at June 30 is as follows (in thousands):

	2018	2017
Assets		
Retirement Plans' interest in the CHI Master Trust	**$ 3,812,898**	$ 3,743,308
Investments in securities	**304,983**	331,168
Receivables for securities sold	**4,234**	14,089
Foreign currency exchange contracts	**30,767**	20,455
Other receivables	**2,907**	6,497
Total assets	**4,155,789**	4,115,517
Liabilities		
Payable for securities purchased	**18,949**	27,324
Foreign currency exchange contracts	**30,846**	20,541
Other liabilities	**188**	270
Total liabilities	**49,983**	48,135
Total Retirement Plans' assets	**$ 4,105,806**	$ 4,067,382

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. ASC 820, *Fair Value Measurements and Disclosures*, establishes a fair value hierarchy that prioritizes the inputs 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 inputs) and the lowest priority to unobservable inputs (Level 3 inputs) as further described in Note 8.

11. Retirement Plans (continued)

The Retirement Plans' financial instruments measured at fair value on a recurring basis were determined using the following inputs at June 30 (in thousands):

	2018			
	Fair Value Measurements at Reporting Date Using			
		(Level 1)	(Level 2)	(Level 3)
	Total	Quoted Prices in Active Markets	Other Observable Inputs	Unobservable Inputs
Assets				
Cash and short-term investments	**$ 132,212**	**$ 83,282**	**$ 48,930**	**$ –**
Equity securities	**3,019**	**293**	**2,726**	**–**
Fixed-income securities	**169,752**	**34,726**	**130,092**	**4,934**
Investments in securities	**304,983**	**118,301**	**181,748**	**4,934**
Foreign currency exchange contracts	**30,767**	**–**	**30,767**	**–**
Total assets	**$ 335,750**	**$ 118,301**	**$ 212,515**	**$ 4,934**
Liabilities				
Foreign currency exchange contracts	**$ 30,846**	**$ –**	**$ 30,846**	**$ –**
Total liabilities	**$ 30,846**	**$ –**	**$ 30,846**	**$ –**

	2017			
	Fair Value Measurements at Reporting Date Using			
		(Level 1)	(Level 2)	(Level 3)
	Total	Quoted Prices in Active Markets	Other Observable Inputs	Unobservable Inputs
Assets				
Cash and short-term investments	$ 62,061	$ 55,925	$ 6,136	$ –
Equity securities	44,679	38,796	5,883	–
Fixed-income securities	224,428	47,209	173,068	4,151
Investments in securities	331,168	141,930	185,087	4,151
Foreign currency exchange contracts	20,455	–	20,455	–
Total assets	$ 351,623	$ 141,930	$ 205,542	$ 4,151
Liabilities				
Foreign currency exchange contracts	$ 20,541	$ –	$ 20,541	$ –
Total liabilities	$ 20,541	$ –	$ 20,541	$ –

11. Retirement Plans (continued)

The changes in fair value of the Retirement Plans' investments in securities, for which Level 3 inputs were used, are as follows (in thousands):

Investments at fair value at July 1, 2016	$ 21,395
Purchases of investments	6,145
Sales of investments	(22,621)
Net change in unrealized loss on investments, including foreign currency changes	(172)
Net realized loss on investments, including foreign currency changes	(596)
Investments at fair value at June 30, 2017	4,151
Purchases of investments	**4,560**
Sales of investments	**(2,688)**
Net change in unrealized loss on investments, including foreign currency changes	**(31)**
Net realized loss on investments, including foreign currency changes	**(1,058)**
Investments at fair value at June 30, 2018	**$ 4,934**

There were no significant transfers in or out of Level 3 during any period presented.

Certain of the Retirement Plans' investments are held in the CHI Master Trust, which was established for the investment of assets of the Retirement Plans. Each participating plan has an undivided interest in the CHI Master Trust. The CHI Master Trust assets are allocated among the participating plans by assigning to each plan those transactions (primarily contributions, benefit payments, and plan-specific expenses) that can be specifically identified and by allocating among all plans, in proportion to each plan's beneficial interest in the CHI Master Trust, income and expenses resulting from the collective investment of the assets of the CHI Master Trust.

The CHI Master Trust investment portfolio is designed to preserve principal and obtain competitive investment returns and long-term investment growth, consistent with actuarial assumptions, while minimizing unnecessary investment risk. Diversification is achieved by allocating assets to various asset classes and investment styles and by retaining multiple investment managers with complementary philosophies, styles and approaches. Although the objective of the CHI Master Trust is to maintain targeted asset allocations, temporary periods may exist where allocations are outside of the expected range due to market conditions. The use of leverage is prohibited except as specifically directed in the alternative investment allocation. The portfolio is managed on a basis consistent with the CHI social responsibility guidelines.

11. Retirement Plans (continued)

The CHI Master Trust asset allocation at June 30 is as follows:

	2018	2017
Equity securities	**47%**	48%
Fixed-income securities	**34**	33
Alternative investments	**19**	19
	100%	100%

The CHI Finance Committee (the Committee) of the Board of Stewardship Trustees is responsible for determining targeted asset allocations among fixed-income, equity, and alternative investments. At least annually, the Committee reviews targeted allocations and, if necessary, makes adjustments to targeted asset allocations. Given the diversity of the underlying securities in which the CHI Master Trust invests, management does not believe there is a significant concentration of credit risk.

The CHI Master Trust allocation to alternative investments is based upon contractual commitment levels to various funds. These commitments are drawn by the fund managers as opportunities arise to invest the capital. As of June 30, 2018, the CHI Master Trust had committed to invest $420.5 million in 27 funds, of which $378.5 million had been invested. The remaining $42.0 million will be invested when, and if, requested by the funds. Alternative investments within the CHI Master Trust have limited liquidity and as of June 30, 2018, $105.6 million of investments are illiquid and not available for redemption, and $619.9 million of investments are available for redemption within 180 days at the request of the CHI Master Trust.

11. Retirement Plans (continued)

A summary of the CHI Master Trust's assets at June 30 is as follows (in thousands). At June 30, 2018 and 2017, the Retirement Plans' interest in the net assets of the CHI Master Trust was approximately 100.0% and 99.9%, respectively.

	2018	2017
Assets		
Investments in securities	**$ 3,813,906**	$ 3,719,449
Receivables for securities sold	**28,700**	68,884
Foreign currency exchange contracts	**57,542**	49,037
Other receivables	**12,778**	11,618
Total assets	**3,912,926**	3,848,988
Liabilities		
Payable for securities purchased	**39,831**	53,561
Foreign currency exchange contracts	**57,405**	49,408
Other liabilities	**2,792**	2,706
Total liabilities	**100,028**	105,675
Total CHI Master Trust assets	**$ 3,812,898**	$ 3,743,313

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. ASC 820, *Fair Value Measurements and Disclosures*, establishes a fair value hierarchy that prioritizes the inputs 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 inputs) and the lowest priority to unobservable inputs (Level 3 inputs) as further described in Note 8.

The fair values of alternative investments are not publicly traded, nor are there generally readily available market quotations to be used for valuation purposes. Accordingly, the valuations of alternative investments are measured at the net asset value (NAV) practical expedient as of the reporting date, as reported by fund managers, and are excluded from the three-level hierarchy for fair value measurements in accordance with ASC Topic 820.

11. Retirement Plans (continued)

The CHI Master Trust's financial instruments measured at fair value on a recurring basis were determined using the following inputs at June 30 (in thousands):

2018

	Investments		Fair Value Measurements at Reporting Date Using			
				(Level 1)	(Level 2)	(Level 3)
	Total	**Measured at NAV**	**Total**	**Quoted Prices in Active Markets**	**Other Observable Inputs**	**Unobservable Inputs**
Assets						
Cash and short-term investments	**$ 90,826**	**$ –**	**$ 90,826**	**$ 85,993**	**$ 4,833**	**$ –**
Equity securities	**1,743,129**	**–**	**1,743,129**	**1,740,594**	**2,535**	**–**
Fixed-income securities	**1,246,718**	**–**	**1,246,718**	**349,221**	**714,002**	**183,495**
Alternative investments	**733,233**	**733,233**	**–**	**–**	**–**	**–**
Investments in securities	**3,813,906**	**733,233**	**3,080,673**	**2,175,808**	**721,370**	**183,495**
Foreign currency exchange contracts	**57,542**	**–**	**57,542**	**–**	**57,542**	**–**
Total assets	**$ 3,871,448**	**$ 733,233**	**$ 3,138,215**	**$ 2,175,808**	**$ 778,912**	**$ 183,495**
Liabilities						
Foreign currency exchange contracts	**$ 57,405**	**$ –**	**$ 57,405**	**$ –**	**$ 57,405**	**$ –**
Total liabilities	**$ 57,405**	**$ –**	**$ 57,405**	**$ –**	**$ 57,405**	**$ –**

2017

	Investments		Fair Value Measurements at Reporting Date Using			
				(Level 1)	(Level 2)	(Level 3)
	Total	**Measured at NAV**	**Total**	**Quoted Prices in Active Markets**	**Other Observable Inputs**	**Unobservable Inputs**
Assets						
Cash and short-term investments	$ 106,397	$ –	$ 106,397	$ 100,642	$ 5,755	$ –
Equity securities	1,710,426	–	1,710,426	1,707,864	2,562	–
Fixed-income securities	1,171,383	–	1,171,383	330,660	662,532	178,191
Alternative investments	731,243	731,243	–	–	–	–
Investments in securities	3,719,449	731,243	2,988,206	2,139,166	670,849	178,191
Foreign currency exchange contracts	49,037	–	49,037	–	49,037	–
Total assets	$ 3,768,486	$ 731,243	$ 3,037,243	$ 2,139,166	$ 719,886	$ 178,191
Liabilities						
Foreign currency exchange contracts	$ 49,408	$ –	$ 49,408	$ –	$ 49,408	$ –
Total liabilities	$ 49,408	$ –	$ 49,408	$ –	$ 49,408	$ –

11. Retirement Plans (continued)

The changes in fair value of the CHI Master Trust's investments, for which Level 3 inputs were used, are as follows (in thousands):

Investments at fair value at July 1, 2016	$ 164,146
Purchases of investments	166,065
Sales of investments	(155,094)
Net change in unrealized gain on investments, including foreign currency changes	5,556
Net realized loss on investments, including foreign currency changes	(2,482)
Investments at fair value at June 30, 2017	178,191
Purchases of investments	**140,185**
Sales of investments	**(135,273)**
Net change in unrealized loss on investments, including foreign currency changes	**(138)**
Net realized gain on investments, including foreign currency changes	**530**
Investments at fair value at June 30, 2018	**$ 183,495**

There were no significant transfers in or out of Level 3 during any period presented.

CHI 401(k) Retirement Savings Plan

CHI sponsors the CHI 401(k) Retirement Savings Plan (401(k) Savings Plan) for its employees whereby CHI matches 100.0% of the first 1.0% of eligible pay an employee contributes to the plan, and 50.0% of the next 5.0% of eligible pay contributed to the plan, for a maximum employer matching rate of 3.5% of eligible pay. On an annual basis and regardless of whether or not an employee participates in the 401(k) Savings Plan, CHI will also contribute 2.5% of eligible pay to an employee's 401(k) Savings Plan account. This contribution is made if an employee reaches 1,000 hours in the first year of employment, or every calendar year thereafter, and is employed on the last day of the calendar year. An employee is fully vested in the plan for employer contributions after three years of service. CHI recorded 401(k) Savings Plan expense of $218.8 million and $224.2 million for the years ended June 30, 2018 and 2017, respectively, which is reflected in employee benefits expenses in the accompanying consolidated statements of operations.

12. Concentrations of Credit Risk

CHI grants credit without collateral to its patients, most of whom are insured under third-party payor agreements. CHI's exposure to credit risk on patient accounts receivable is limited by the geographical diversity of its MBOs.

The mix of net patient accounts receivable at June 30 approximated the following:

	2018	2017
Medicare	**26%**	26%
Medicaid	**10**	14
Managed care	**34**	33
Self-pay	**11**	10
Commercial and other	**19**	17
	100%	100%

CHI maintains long-term investments with various financial institutions and investment management firms through its investment program, and its policy is designed to limit exposure to any one institution or investment. Management does not believe there are significant concentrations of credit risk at June 30, 2018 and 2017.

13. Commitments and Contingencies

Litigation

During the normal course of business, CHI may become involved in litigation. Management assesses the probable outcome of unresolved litigation and records estimated settlements. After consultation with legal counsel, management believes that any such matters will be resolved without material adverse impact to the consolidated financial position or results of operations of CHI.

13. Commitments and Contingencies (continued)

Health Care Regulatory Environment

The health care industry is subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Management believes CHI is in compliance with all applicable laws and regulations of the Medicare and Medicaid programs. Compliance with such laws and regulations is complex and can be subject to future governmental interpretation as well as significant regulatory action, including fines, penalties and exclusion from the Medicare and Medicaid programs. Certain CHI entities have been contacted by governmental agencies regarding alleged violations of Medicare practices for certain services. In the opinion of management after consultation with legal counsel, the ultimate outcome of these matters will not have a material adverse effect on CHI's consolidated financial statements.

Operating Leases

CHI leases certain real estate and equipment under operating leases, which may include renewal options and escalation clauses. Future minimum lease payments required for the next five years and thereafter for all operating leases that have initial or remaining noncancelable lease terms in excess of one year at June 30, 2018, are as follows (in thousands):

	Amounts Due
Year Ending June 30:	
2019	$ 223,508
2020	194,822
2021	172,060
2022	150,054
2023	128,821
Thereafter	398,064
	$ 1,267,329

Lease expense under operating leases for continuing operations for the years ended June 30, 2018 and 2017, totaled approximately $329.4 million and $288.3 million, respectively.

13. Commitments and Contingencies (continued)

Capital Commitments

As of June 30, 2018, CHI has legally committed to fund $669.2 million of capital improvements related to certain acquisitions and affiliations.

14. Insurance Programs

FIIL, a wholly owned captive insurance company of CHI, provides professional liability, employment practices liability, miscellaneous professional liability, and commercial general liability coverage, primarily to CHI healthcare providers and all employees, including employed providers. Coverage is provided either on a direct written basis or through a reinsurance fronting relationship with commercial insurance carriers. Policies written provide coverage with primary limits in the amount of $10.0 million for each and every claim in fiscal years 2018 and 2017. For the policy year July 1, 2017 to July 1, 2018 (and in the prior year), there is an annual policy aggregate of $85.0 million eroded by professional liability and commercial general liability claims, subject to a $175,000 continuing underlying per claim limit. Effective July 1, 2011, FIIL provided excess umbrella liability coverage to CHI for claims in excess of the underlying limits discussed above. The limits provided under such excess coverage are $200.0 million per claim and in the aggregate. FIIL reinsured 100% of the excess layer with various commercial insurance companies. At June 30, 2018 and 2017, investments and assets limited as to use held for insurance purposes included $48.3 million and $55.9 million, respectively, held as collateral for the reinsurance fronting arrangement.

FIIL provided workers' compensation coverage to CHI entities on a directly written basis for the current and prior fiscal years, with limits of liability of $1 million per claim. FIIL did not reinsure this coverage for the current and prior fiscal years.

The liability for self-insured reserves and claims represents the estimated ultimate net cost of all reported and unreported losses incurred through June 30. The reserves for unpaid losses and loss adjustment expenses are estimated using individual case-based valuations, statistical analyses and the expertise of an independent actuary.

The estimates for loss reserves are subject to the effects of trends in loss severity and frequency. Although considerable variability is inherent in such estimates, management believes that the reserves for unpaid losses and loss adjustment expenses are adequate. The estimates are reviewed periodically, with consultation from independent actuaries, and any adjustments to the loss reserves are reflected in current operations. As a result of these reviews of claims experience,

14. Insurance Programs (continued)

estimated reserves were reduced by $70.3 million and $63.3 million in fiscal years 2018 and 2017, respectively. The reserves for unpaid losses and loss adjustment expenses relating to the workers' compensation program were discounted, assuming a 4.0% annual return at June 30, 2018 and 2017, to a present value of $147.7 million and $155.5 million at June 30, 2018 and 2017, respectively, and represented a discount of $48.5 million and $50.2 million at June 30, 2018 and 2017, respectively. Reserves related to professional liability, employment practices and general liability are not discounted.

FIIL holds $817.2 million and $848.8 million of investments held for insurance purposes as of June 30, 2018 and 2017, respectively. Distribution of amounts from FIIL to CHI are subject to the approval of the Cayman Island Monetary Authority. CHI established a captive management operation (Captive Management Initiatives, Ltd.) based in the Cayman Islands, which currently manages FIIL as well as operations of other unrelated parties.

CHI, through its Welfare Benefit Administration and Development Trust, provides comprehensive health and dental coverage to certain employees and dependents through a self-insured medical plan. Accounts payable and accrued expenses include $54.3 million and $58.8 million for unpaid claims and claims adjustment expenses for CHI's self-insured medical plan at June 30, 2018 and 2017, respectively. Those estimates are subject to the effects of trends in loss severity and frequency. Although considerable variability is inherent in such estimates, management believes that the reserves for unpaid losses and loss adjustment expenses are adequate. The estimates are reviewed periodically and, as adjustments to the liability become necessary, such adjustments are reflected in current operations. CHI has stop-loss insurance to cover unusually high costs of care beyond a predetermined annual amount per enrolled participant.

15. Subsequent Events

CHI's management has evaluated events subsequent to June 30, 2018 through September 27, 2018, which is the date these consolidated financial statements were issued. There have been no material events noted during this period that would either impact the results reflected herein or CHI's results going forward, except as disclosed herein.

In September 2018, CHI joined with six major, nationally recognized health systems to form Civica Rx, a nonprofit generic drug company that will help patients by addressing shortages and high prices of life saving medications. As an FDA-approved manufacturer, Civica Rx will either directly manufacture general drugs or sub-contract manufacturing with reputable organizations. Civica Rx will first seek to stabilize the supply of essential generic medications administered in hospitals, since many of the medications are in chronic short supply. Civica Rx expects to have its first products on the market as early as 2019.

Supplementary Information

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Report of Independent Auditors on Supplementary Information

The Board of Stewardship Trustees
Catholic Health Initiatives

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements of Catholic Health Initiatives as a whole. The consolidating details appearing in conjunction with the financial statements are presented for purposes of additional analysis and are not a required part of the consolidated 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 financial statements. The information has been subjected to the auditing procedures applied in our audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the information is fairly stated, in all material respects, in relation to the financial statements as a whole.

Ernst & Young LLP

September 27, 2018

A member firm of Ernst & Young Global Limited

Catholic Health Initiatives

Consolidating Balance Sheet

June 30, 2018
(In Thousands)

	MBOs	Corporate	FIIL	CHI Welfare Benefits Trust	Other	Eliminations and Adjustments	Consolidated
Assets							
Current assets:							
Cash and equivalents	$ 657,504	$ (310,901)	$ 86	$ 50,068	$ 113,699	$ –	$ 510,456
Net patient accounts receivable, less allowance for bad debts of $827,130	2,135,402	–	–	–	–	(13,820)	2,121,582
Other accounts receivable	235,213	475,019	605	(56)	3,707	(457,203)	257,285
Current portion of investments and assets limited as to use	5,831	58,517	–	–	–	–	64,348
Inventories	298,636	–	–	–	–	–	298,636
Assets of discontinued operations and held for sale	28,083	–	–	–	167,615	–	195,698
Prepaid and other	65,726	77,795	41	–	441	–	144,003
Total current assets	3,426,395	300,430	732	50,012	285,462	(471,023)	3,592,008
Investments and assets limited as to use:							
Internally designated for capital and other funds	5,119,889	166,273	–	39,302	–	(16,596)	5,308,868
Held by trustees	11,141	64,939	–	–	–	–	76,080
Held for insurance purposes	112	–	817,237	–	12,053	–	829,402
Restricted by donors	257,183	1,205	–	–	125	–	258,513
Total investments and assets limited as to use	5,388,325	232,417	817,237	39,302	12,178	(16,596)	6,472,863
Property and equipment, net	7,450,237	649,829	–	–	10,701	–	8,110,767
Investments in unconsolidated organizations	999,527	1,069,837	–	–	14,773	(351,297)	1,732,840
Intangible assets and goodwill, net	409,288	12,100	–	–	–	–	421,388
Notes receivable and other	811,905	3,077,602	36,135	3,010	54	(3,663,265)	265,441
Total assets	$ 18,485,677	$ 5,342,215	$ 854,104	$ 92,324	$ 323,168	$ (4,502,181)	$ 20,595,307

Continued on following page

Catholic Health Initiatives

Consolidating Balance Sheet (continued)

June 30, 2018
(In Thousands)

	MBOs	Corporate	FIIL	CHI Welfare Benefits Trust	Other	Eliminations and Adjustments	Consolidated
Liabilities and net assets							
Current liabilities:							
Compensation and benefits	$ 443,284	$ 113,012	$ –	$ 1,561	$ 11,129	$ –	$ 568,986
Third-party liabilities, net	131,670	–	–	–	–	–	131,670
Accounts payable and accrued expenses	1,512,227	367,575	6,072	54,276	11,238	(471,023)	1,480,365
Liabilities of discontinued operations held for sale	92,369	–	–	–	159,341	–	251,710
Variable-rate debt with self-liquidity	–	96,700	–	–	–	–	96,700
Current portion of long-term debt	223,579	2,009,051	–	–	–	(145,224)	2,087,406
Total current liabilities	2,403,129	2,586,338	6,072	55,837	181,708	(616,247)	4,616,837
Pension liability	115,078	747,362	–	–	–	(8,013)	854,427
Self-insured reserves and claims	1,038	3,636	618,650	–	(57)	–	623,267
Other liabilities	407,476	618,593	–	–	1,022	–	1,027,091
Long-term debt	3,394,225	6,455,347	–	–	10,700	(3,518,341)	6,341,931
Total liabilities	6,320,946	10,411,276	624,722	55,837	193,373	(4,142,601)	13,463,553
Net assets:							
Net assets attributable to CHI	11,562,140	(5,069,434)	229,382	36,487	129,640	(359,580)	6,528,635
Net assets attributable to noncontrolling interests	300,496	(68)	–	–	–	–	300,428
Unrestricted	11,862,636	(5,069,502)	229,382	36,487	129,640	(359,580)	6,829,063
Temporarily restricted	207,099	441	–	–	155	–	207,695
Permanently restricted	94,996	–	–	–	–	–	94,996
Total net assets	12,164,731	(5,069,061)	229,382	36,487	129,795	(359,580)	7,131,754
Total liabilities and net assets	$ 18,485,677	$ 5,342,215	$ 854,104	$ 92,324	$ 323,168	$ (4,502,181)	$ 20,595,307

Catholic Health Initiatives

Consolidating Statement of Operations

June 30, 2018
(In Thousands)

	MBOs	Corporate	FIIL	CHI Welfare Benefits Trust	Other	Eliminations and Adjustments	Consolidated
Revenues:							
Net patient services revenues	$ 14,305,223	$ –	$ –	$ –	$ –	$ (168,849)	$ 14,136,374
Other operating revenues:							
Donations	41,720	3	–	–	30	–	41,753
Changes in equity of unconsolidated organizations	(35,718)	39,149	–	–	(749)	15,776	18,458
Hospital ancillary revenues	348,352	–	–	–	1,969	–	350,321
Other	344,010	1,623,456	167,155	628,905	308,453	(2,636,798)	435,181
Total other operating revenues	698,364	1,662,608	167,155	628,905	309,703	(2,621,022)	845,713
Total operating revenues	15,003,587	1,662,608	167,155	628,905	309,703	(2,789,871)	14,982,087
Expenses:							
Salaries and wages	5,713,518	274,607	–	–	192,645	(184,815)	5,995,955
Employee benefits	1,272,381	20,133	23,475	630,035	54,784	(886,244)	1,114,564
Purchased services, medical professional fees and consulting	2,494,221	849,945	12,263	2,194	60,289	(1,117,912)	2,301,000
Supplies	2,451,224	(3,740)	–	–	32	–	2,447,516
Utilities	174,977	21,360	–	–	91	–	196,428
Rentals, leases, maintenance and insurance	571,853	509,849	94,930	–	1,373	(294,563)	883,442
Depreciation and amortization	713,081	141,498	–	–	1,609	–	856,188
Interest	165,748	291,777	–	–	518	(145,272)	312,771
Other	1,143,373	32,990	509	739	8,883	(176,841)	1,009,653
Total operating expenses before restructuring, impairment and other losses	14,700,376	2,138,419	131,177	632,968	320,224	(2,805,647)	15,117,517
Income (loss) from operations before restructuring, impairment and other losses	303,211	(475,811)	35,978	(4,063)	(10,521)	15,776	(135,430)
Restructuring, impairment and other losses	55,877	79,140	5,897	–	369	–	141,283
Income (loss) from operations	247,334	(554,951)	30,081	(4,063)	(10,890)	15,776	(276,713)
Nonoperating gains (losses):							
Investment gains, net	377,621	24,713	33,554	3,653	31	2,924	442,496
Gains on early extinguishment of debt	208	–	–	–	–	–	208
Realized and unrealized gains on interest rate swaps	5,759	46,364	–	–	–	–	52,123
Other nonoperating gains (losses)	3,987	–	–	–	–	–	3,987
Total nonoperating gains	387,575	71,077	33,554	3,653	31	2,924	498,814
Excess (deficit) of revenues over expenses	634,909	(483,874)	63,635	(410)	(10,859)	18,700	222,101
Excess (deficit) of revenues over expenses attributable to noncontrolling interest	31,448	(2,999)	–	–	–	–	28,449
Excess (deficit) of revenues over expenses attributable to CHI	$ 603,461	$ (480,875)	$ 63,635	$ (410)	$ (10,859)	$ 18,700	$ 193,652

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