...through love serve one another.

Galatians 5:13
Our Mission

The mission of Catholic Health Initiatives is to nurture the healing ministry of the Church by bringing it new life, energy and viability in the 21st century. Fidelity to the Gospel urges us to emphasize human dignity and social justice as we move toward the creation of healthier communities.

Our Vision

Catholic Health Initiatives’ vision is to create a national Catholic ministry which will live out its mission by transforming traditional health care delivery into integrated networks and creating new ministries that promote healthy communities.

Our Core Values

Catholic Health Initiatives’ core values define the organization and serve as its guiding principles. They are the roots or anchors from which all activities, decisions and behaviors follow.

Reverence
Profound respect and awe for all of creation, the foundation that shapes spirituality, our relationships with others and our journey to God.

Integrity
Moral wholeness, soundness, fidelity, trust, truthfulness in all we do.

Compassion
Solidarity with one another, capacity to enter into another’s joy and sorrow.

Excellence
Preeminent performance, becoming the benchmark, putting forth our personal and professional best.
... strengthening the fabric of life in our communities.
The building of healthy communities is so integral to the identity of Catholic Health Initiatives that it is part of both our mission and vision statements. This commitment is expressed in many ways. This year, our Mission and Ministry Fund continues to support initiatives that create healthy communities. Our Direct Community Investment Program made its debut and now supports numerous organizations that promote the strength and health of their communities.

What has also served as an inspiration to us this year are the wonderful collaborative models for community health that are emerging from our market-based organizations. We are pleased to present the stories and accomplishments of some of these partnerships in this annual report. With a true spirit of innovation, these partnerships are overcoming barriers, trying new ideas and breaking new ground by creating not “just another program,” but by strengthening the fabric of life in our communities.

This is what our market-based organizations and their collaborators work to achieve: healthy community initiatives that wrap around communities like a favorite warm jacket. Each initiative is a good fit that suits the needs of the community. They bind individuals and organizations together so they can pursue their goals in harmony. They empower all they serve to go about their daily lives with a greater sense of health and well being.

This year has also brought challenges to Catholic Health Initiatives and to all health care providers. Everyone in our organization is drawing on resources of knowledge and faith to maintain vitality in our ministry. But even in the midst of unprecedented trials, the healthy community initiatives of our market-based organizations flourish. Their focus on community-wide participation in planning, goal setting and achievement is a modern expression of the message of Paul in Galatians: ... through love serve one another. It is also an exciting model for the future of our health ministry.
We are pleased to present the stories and accomplishments of some of these partnerships... With a true spirit of innovation, these partnerships are overcoming barriers, trying new ideas and breaking new ground by creating not “just another program,” but by strengthening the fabric of life in our communities.
Healthy Neighborhoods Project
Project Partner: St. Francis Healthcare Services, Wilmington, Delaware

It was a gunshot in the middle of an otherwise quiet day that brought neighbors and community organizations together for the sake of a Wilmington, Del., neighborhood. Rather than causing residents of the Ninth Ward neighborhood to retreat in fear, the response to that single act of violence started a chain reaction that resulted in the Healthy Neighborhoods Project. The shot was heard by children whose mother approached the principal of Christ Our King School to talk about ways to make neighborhood children feel safer. That was the first step in a movement that now includes neighborhood residents and supporters such as St. Francis Healthcare Services and the Sisters of St. Francis of Philadelphia, who sought and received a grant for the project from Catholic Health Initiatives’ Mission and Ministry Fund. Now, the neighborhood’s children are learning to be peacemakers, and their brothers and sisters, teachers, parents and neighbors have banded together as stakeholders in a true grassroots effort to revitalize the Ninth Ward. With two priorities — promoting a safe and livable neighborhood and building self-esteem in adolescents — the stakeholders will build on the neighborhood’s assets, which include diversity and an obvious commitment to one another.

These fifth grade students from Christ Our King School — (from left) Quinn Fisher, Rita Jacobs, Lonja Congo, Shané Darby, Alex Carter and Ariel Jackson — work with their teacher, Adolphus Fletcher, to help make the Ninth Ward a peaceful place.
The Healthy Neighborhoods Project is based on the McKnight-Kretzmann model of community mobilization, developed at Northwestern University. The model builds a shared vision among stakeholders and assesses strengths on which the community can build before making any sweeping changes. This approach was important to all of the project partners, which also included the Diocese of Wilmington, Catholic Charities, Neumann College, Aston, Pa., and Christ Our King Parish and School.

However, it took time for the Ninth Ward neighborhood to accept, trust and support the process. “We met resistance from a few community leaders,” said Toria Ray-Larkin, director of the project. “They didn’t want another program to tell them what to do. We kept explaining our mission, which is to work together, to share decision making and to ensure that people who are doing good things in the neighborhood know each other.”

The project’s coordinating committee knew their message was finally heard when 350 residents turned out for a summer gathering in a neighborhood park. Amid the festivities, residents voted on project priorities and formally signed on as stakeholders. “Outcomes for a project like this can be hard to measure on a scale of one to ten,” said Patricia Hutchison, OSF, chair of the coordinating committee. “But you know it’s working when you see people in the neighborhood who didn’t know each other before become friends.”

“...The community members are the experts. We’re the steering committee. They tell us what they want the next step to be.”

Toria Ray-Larkin, Director, Healthy Neighborhoods Project
Andrea, Joel, Lacey, Melissa and Gene, students at Pleasanton High School in Buffalo County, Neb., know all about peer pressure to experiment with drugs and alcohol. But, they are counteracting that through their participation in a Youth Congress sponsored by Positive Pressure, a work group of the Buffalo County Community Health Partners. Positive Pressure is a grassroots effort to educate students and parents about drugs such as methamphetamine and is one of many facets of a shared vision that is driving the work of the partners. The partners, including more than 20 organizations and 300 volunteers, focus on what is important to the community: a strong sense of community, holistic health, education, the local economy and environment. Good Samaritan Health Systems provided seed money — $100,000 for three consecutive years — as start-up resources. With these funds, the partners are providing grants to collaborative ventures that bring existing forces for community health together in meaningful new ways as they work toward the partnership’s goals. For example, at the Youth Congress, 170 high school students set their own agendas for preventing drug and alcohol abuse. One student’s evaluation: “It wasn’t about instilling prefabricated ideas. It was about brainstorming what we are going to do.”

“Positive Pressure is an example of everything the partnership stands for. The community recognized the problem of drugs and alcohol and their impact on youth and formed Positive Pressure to involve the community and empower youth.”

Joan Lindenstein, Assistant Vice President, Community Health Development, Good Samaritan Health Systems and Chair, Buffalo County Community Health Partners

Students pictured (left to right): Andrea Geisler, Joel Bednar, Lacey Daake, Melissa Nunley and Eugene Unick.
Goals Set, Goals Reached

Based on a comprehensive community health assessment, surveys of residents and months of debate and discussion, the Buffalo County Community Health Partners adopted specific goals in 15 priority health areas:

- Affordable Housing
- Alcohol Use
- Alzheimer’s Disease
- Assisted Living
- Child Abuse
- Domestic Violence
- Immunizations
- Maintaining the Independence of Older Adults
- Obesity
- Preventing Adverse Drug Interactions
- Suicide Prevention
- Teenage Pregnancy
- Teenage Smoking
- Transportation
- Water Quality

While the partners are working to reach all 15 goals by 2001, two have already been met:

**Assisted Living** The goal to increase the number of licensed assisted-living units from a baseline of 58 by 10 percent per year has been exceeded. By 2001, there will be 230 units in Buffalo County.

**Transportation Goal** The goal to increase utilization and access to surface transportation services other than individual vehicles by five percent per year has been exceeded, with the number of passengers using public transportation more than doubling from 1995 to 1997.

Forming a Cohesive County-wide Partnership

Advice from Joan Lindenstein, chair of the Buffalo County Community Health Partners:

- Base goals on demonstrated quantitative or qualitative needs that are identified through a formal assessment process.
- Search for volunteers who have a passion to improve community health in a specific area.
- Go slow to move fast: take time to plan and reach a consensus for action, even when a problem is urgent.
- Consider in advance how to terminate a goal when it is met or doesn’t generate interest, and how to integrate new goals.
“The Partnership for Children is an excellent example of an initiative that is willing to work with existing agencies and new partners. Our intention is to make it a widely used model for creating a community of healthy children and families.”

Howard Roddy, Vice President, Healthy Community Initiatives, Memorial Health Care System, Chattanooga, Tennessee
Jasmine Smith feels comfortable during an exam by Allyson Neal, nurse practitioner with the Partnership for Children in Chattanooga, Tennessee.
When asked to improve the health and well-being of children, even the staunchest competitors can find a way to put their differences aside. In Chattanooga, Tenn., hospitals and social service agencies that used to vie for funding and visibility now work together as the Partnership for Children. The mainstay of the program is a model that combines two successful and complementary programs, First Steps and Building Blocks. First Steps, originally offered by T.C. Thompson Children’s Hospital, is a prenatal program to ensure healthy births and to prevent child maltreatment; Building Blocks, originally offered by Memorial Hospital, provides medical, social and childhood development guidance to children and their parents from birth through the age of five. Now, the Partnership for Children coordinates both programs and serves as an umbrella for numerous other agencies and organizations that want all children to have a healthy start in life.
Statistics Show Need for Collaboration

Safeguarding the health of children is a popular basis for healthy community collaborations. In Chattanooga, statistics show that collaboration for children’s health is a pressing need as well.

- Of the nearly 19,000 children under the age of five in Hamilton County, population estimates show that nearly 4,500 live in poverty and more than 5,000 live in single-parent homes.
- County records from 1998 show that more than 700 babies were born to girls under the age of 19, 98 percent of whom were single mothers.

“...is an excellent example of an initiative that is willing to work with existing agencies and new partners. Our intention is to make it a widely used model for creating a community of healthy children and families.”

Howard Roddy, Vice President, Healthy Community Initiatives, Memorial Health Care System

Working Toward a Self-sustaining Organization

Project Partners cite several factors that can contribute to the successful start of a healthy community partnership:

- Find collaborators with shared values; in this case, organizations committed to serving children and families were willing to set competition aside to share information and ideas.
- In creating a vision for the partnership, have each partner clearly state its goals — such as networking or gaining visibility in the community — so that the partnership is comfortable with and can serve those needs.
- Make sure each collaborator promotes the initiative as a true partnership in which no one shoulders all the work or takes all the credit.
- Nurture the partnership and build a solid infrastructure so it can eventually become a self-sustaining organization.
Healthy Polk 2000
Project Partner: Mercy Medical Center, Des Moines, Iowa

Suzanne Tovar, nursing director of cardiac/trauma in the surgical intensive care unit at Mercy Medical Center in Des Moines, Iowa, helps Julie Shannon improve her cardiovascular health.
When Julie works out on a treadmill at Mercy Medical Center in Des Moines, Iowa, it’s something that she has to do on her own, one step after another. Still, Suzanne Tovar, nursing director of cardiac/trauma in the surgical intensive care unit, supports every step Julie takes to improve her cardiovascular health. So do the 40 organizations, 20 work groups and 300 individuals that form Healthy Polk 2000, an initiative to reduce preventable diseases and injuries among the population of Polk County. Julie is a living example of one of Healthy Polk 2000’s goals in the cardiovascular area: to reduce heart disease and strokes by increasing the number of Polk County residents who exercise at least three times a week. Based on a community health assessment, the coalition set goals in 19 additional health-related areas to be achieved by the year 2000. Now that the new millennium is here, the coalition will use focus groups to assess its progress and set new goals as it evolves into Healthy Polk 2010.

Calling on the Community

Some tips from the leaders of Healthy Polk 2000 on involving community members in this type of initiative:

- No one knows the health needs of a community better than the people who live there, so ask residents for their opinions; Healthy Polk 2000 accomplished this through focus groups. The more participation you can generate, the better the initiative’s chance for success.
- When you ask residents for their opinions, be prepared for responses that are different from what you expect to hear.
- Residents are likely to want to address an extremely wide range of health needs. While many of their requests and ideas will have merit, recognize that the coalition will have to set some parameters and assign priorities.

Running with a State Mandate

Healthy Polk 2000 is based on “Healthy Iowans 2000,” which the state of Iowa published in 1993. Among its goals and accomplishments are:

- **Alcohol and Other Drugs**: Provided intensive training to early childhood workers on children at risk.
- **Cancer**: Decreased the incidence of cancer among Polk County women.
- **Cardiovascular**: Conducted blood pressure and stroke screenings.
- **Clinical Preventive Services**: Founded a minority health coalition.
- **Diabetes and Chronic Disabling Conditions**: Obtained a Wellmark Foundation grant for diabetes screening.
- **Environmental Health**: Developed guidelines for response to a bioterrorism, chemical or nuclear event.
- **Food Safety**: Maintained a low incidence of salmonella enteritis.
- **Immunization and Infectious Diseases**: Added private providers to Iowa’s Immunization Information System.
- **Lead Poisoning**: Created a coalition to address lead poisoning.
- **Mental Health**: Developed a guide to county mental health providers.
- **Nutrition and Physical Fitness**: Developed wellness standards for use in physician offices.
- **Oral Health**: Provided free oral health screenings to children.
- **Tobacco**: Promoted legislative changes for prevention of tobacco use.
- **Unintentional Injuries**: Conducted a “Safety Town” project for children.
- **Zero Tolerance for Violence**: Organized a domestic violence prevention conference.

“*The success of any effort like Healthy Polk 2000 depends on interaction with the community. The community sets the needs, and we do our best to respond.*”

Annette Bair, Vice President, Mission and Ethics, Mercy Medical Center
Thursday is a favorite day for these residents of the Leavenworth neighborhood in downtown Omaha, Neb. It’s activity day at the Sunshine Club, which is comprised of individuals whose advancing age, illness or disability could otherwise isolate them from their community. The club, part of Project SUN (Strong Urban Neighborhoods), makes sure these neighbors connect with each other. Project SUN is supported by Our Healthy Community Partnership, a collaboration that includes Alegent Health and which seeks continuous improvement in community health throughout Douglas and Sarpy Counties. The coalition has the support of the area’s health care institutions as well as four major insurance companies and two medical schools. This group of 26 stakeholder organizations started with a single conversation between two people: the director of the Douglas County Health Department and Norita Cooney, RSM, chair of Alegent Health. They didn’t dream that a few short years later, more than 400 individuals would be involved in building Our Healthy Community.

Focus on Four Priorities

Based on a survey of 10,000 households in Douglas and Sarpy Counties, focus groups and community forums, the partnership selected four initial priorities. Those priorities and a sampling of current projects are:

Youth Substance Abuse and Risky Behavior
The partnership supports Project SUN, a community improvement effort that has developed interventions for adolescents in the Leavenworth neighborhood in downtown Omaha.

Domestic Violence
The project supports the domestic violence initiatives of the YWCA and is developing an advocacy program for children who witness domestic violence.

Continuity of Care
The partnership funded the Urban League’s development of cultural competency training to educate health care providers on unintentional racism.

Tobacco Use
The partnership is engaging young people in “Operation Storefront,” a program that monitors tobacco advertising and retail displays designed to attract youth.

Among the neighbors and volunteers who bask in the warmth of the Sunshine Club are (from left) Kim Ward, Amber Brumfield and Paul Newell.
“We’re not telling the community how to change. We’re here to help them set their own priorities and realize their goals.”

Kerri Peterson, Coordinator, Our Healthy Community Partnership

Urban areas have great potential to attract numerous collaborators for healthy community initiatives, but these tips from the Our Healthy Community Partnership can assist rural initiatives as well:

- Once a core group is formed, develop a concept paper and budget to help bring other collaborators to the table.
- Don’t hesitate to ask competing organizations to participate; competition takes a back seat to a shared commitment to community health.
- Seek action-minded collaborators who don’t want to stop at producing a report on community health.
- Base priorities on surveys or other tools that determine what the community believes is important; when that information can be backed by data, it almost automatically generates interest and support.

Mary Kaczkowski (center), a Project SUN volunteer, helps Elizabeth Capper (at left) and John McGaul with a holiday craft.

For more information, visit the Web site for Our Healthy Community Partnership at www.ohcp.org.
McAuley Project
Project Partner: Mercy Medical Center, Nampa, Idaho

Mercy Medical Center and Mercy Housing Idaho, Inc., the partners behind the McAuley Project, know that people who need social services sometimes lack housing; and, people who don’t have homes often need help obtaining other necessities of life, such as food, clothing, jobs and health assistance. All of these services are now provided in a consistent, coordinated way through the web of relationships woven by the McAuley Project’s case managers, who are integrated into the staffs of several social service agencies in Nampa. The McAuley Project is also providing the leadership necessary to build a new facility that will shelter Nampa’s homeless from the weather and other uncertainties of life.

Women who need protection from domestic violence now find that and so much more at the Valley Crisis Center in Nampa, Idaho.

Getting to the Root of Homelessness

According to Carol Egusquiza, supervisor of the McAuley Project:

- Many agencies, including church and community organizations, work to help the poor and homeless. The McAuley Project provides a linkage between these agencies, which enhances the ability of individuals and families to access services.
- Homeless individuals are frequently unaware of the assistance available to them, so client advocacy is a key function of the McAuley Project.
- It is important to identify the underlying causes of homelessness, and to use case management and/or brief counseling to guide clients toward self-sufficiency.

“The poor of Canyon County are primarily families with young children, and affordable housing and shelter top the list of needs... the McAuley Project... takes a holistic, comprehensive approach to combating homelessness. That broad-based vision is the beauty of this project.”

Editorial, Idaho Press-Tribune
September 1998
During its first 12 months, through June 1999, the McAuley Project served 867 people in multiple ways:

- **325** received case management services.
- **232** benefited from Spanish translation services.
- **214** received assistance with applications for health and welfare programs.
- **244** received housing referrals.
- **132** received funds for emergency shelter.
- **115** received job coaching.

**Adding Value to Social Services**

The Valley Crisis Center is a haven for women like Susan (at right), who receive shelter and referrals to other health and social services through McAuley Project staff members, such as Yolanda Matos (at left).
Operations Realigned for Improved Performance

Catholic Health Initiatives appointed a new chief operating officer, Kevin E. Lofton, and realigned its operational structure to streamline management and move decision making closer to the market-based organizations (MBOs). The position of group president was eliminated and four senior vice presidents of operations were named to work directly with clusters of market-based organizations. In addition, a senior vice president for performance management was appointed for Catholic Health Initiatives. The streamlined structure allows market-based organizations to leverage regional strengths. Catholic Health Initiatives also developed a Health Care Environmental Assessment to help leaders throughout the organization cope with the forces buffeting health care in the United States. The assessment synthesized research findings, supporting data and opinions from a wide variety of health care resources.

Core Strategies Refined

Taking another important step in its evolution, Catholic Health Initiatives refined its original six core strategies to four:

- Extend the creative expression of Catholic Health Initiatives’ ministry.
- Improve clinical, operational and financial performance.
- Build a commitment to service excellence.
- Promote development/growth in areas of highest strategic opportunity.

Web Site, E-mail Help Connect Catholic Health Initiatives

Catholic Health Initiatives established a presence on the Internet with its national Web site: www.catholichealthinitiatives.org

Customized software will be released in early 2000 to help market-based organizations create their own high-quality, cost-efficient Web sites. Catholic Health Initiatives also leveraged technology by establishing e-mail links for 20,000 staff members in 22 states. In addition, public folders allow users to share, via e-mail, internal information such as facility directories, policies and procedures, press releases and to participate in on-line discussion groups.

Investments Build Healthier Communities

Market-based organizations were instrumental in promoting the Direct Community Investment program, which helps build healthy communities through low-interest loans to organizations that provide access to jobs, housing, food, education and health care to those in need. The program progressed toward its goal of investing $32 million, or two percent of Catholic Health Initiatives’ operating investment program assets. By the end of 1999, a total of $11.4 million in direct community investments were made in the following:

- Enterprise Corporation of the Delta, providing financing and technical assistance to small businesses in Mississippi, Arkansas and Louisiana.
- Louisville Community Development Bank, providing financial services to disenfranchised neighborhoods in this Kentucky city.
- Mercy Housing System, providing development and operation of affordable housing in 13 states.
- New Mexico Community Development Fund, providing financing for housing for low-income families in the Tierra Madre Land Trust in Sunland, N.M.
- Northern California Community Loan Fund, providing loans and technical assistance to non-profit organizations in northern California.
- The Reinvestment Fund, providing capital and technical services to help rebuild low-income areas in Pennsylvania and Delaware.
- Self-Help Ventures Fund, providing financial services to promote economic opportunity for employee- and minority-owned businesses in North Carolina.
- Shared Interest, providing a guarantee fund to enhance the flow of credit to low-income communities in South Africa.

Grants Support Innovative Community Health Efforts

Mission and Ministry Fund grants totaling $2.5 million funded 19 innovative initiatives that address the emerging and long-term needs of children, adolescents, women, families and communities. The fund is one of the most visible ways Catholic Health Initiatives lives its mission and extends the healing ministry into the life of the communities it serves. Since 1997, the Mission and Ministry Fund has awarded more than $5.75 million to 60 initiatives.

Advocacy Agenda Seeks Social Justice

Catholic Health Initiatives began to develop a system-wide advocacy agenda for social justice, health care reform and systemic change in building healthy communities. Catholic Health Initiatives combined its resources with those of organizations such as the Catholic Health Association and Catholic Charities USA to act on targeted public policy and regulatory issues. Market-based organizations educated legislators on issues of importance to Catholic health care, forming relationships that will give them a voice in future legislation. An infrastructure to foster communications and resource sharing will support advocacy efforts throughout Catholic Health Initiatives.

Campaigns Counter Medicare Payment Reductions

Catholic Health Initiatives continued to inform policy makers at local, state and national levels of the need for relief from Medicare payment reductions enacted by the Balanced Budget Act of 1997. Grassroots campaigns conducted by the Denver office and market-based organizations asked key legislators to oppose additional reductions and support restoration of Medicare funding. Petitions to congressional representatives were supported by extensive Catholic Health Initiatives outcome data showing the true impact of the Balanced Budget Act.

Assessments Strengthen Mission Integration

Furthering Catholic Health Initiatives’ mission to nurture the healing ministry of the Church by bringing it new life, energy and viability in the 21st century, mission leaders began a system-wide assessment of mission
integration. The assessment considers the extent to which mission is truly integrated into the fabric of the organization. It affirms accomplishments and identifies areas for growth and improvement. In addition, 95 percent of all Catholic Health Initiatives’ employees completed core values orientation.

**Crusade Enrolls Medicaid-eligible Children**

Catholic Health Initiatives joined forces with other Catholic health systems, the Catholic Health Association and Catholic Charities USA to sponsor Children’s Health Matters, a nationwide crusade to enroll 11 million uninsured children in Medicaid and other health insurance programs. The program works to simplify application processes and provide training on Medicaid advocacy and enrollment strategies to hospitals, social service agencies and community groups. Public service announcements, a Web site (www.childrenshealthmatters.org) and educational outreach kits supported the program, which dovetailed with the national “Insure Kids Now” program.

**Clinical Effectiveness Work Expands**

Achieving measurable continuous improvement in patient outcomes and costs remained a top priority for Catholic Health Initiatives as a growing number of market-based organizations engaged in clinical effectiveness work. Through this initiative, clinical leaders and market-based organizations work together to improve quality while controlling costs. To help hospital-owned physician practices achieve break-even budgets, Catholic Health Initiatives formed the Management Assistance Clinic Break Even Team, also called “Macbeth.” The Macbeth process, detailed in the Catholic Health Initiatives book *Breaking Even*, guides physician practices toward improved performance.

**Distinctive Culture Fosters Visionary Spirit**

Catholic Health Initiatives began to develop the distinctive culture that is essential to meet the opportunities and challenges for the health ministry in the 21st century. Culture is the way people in an organization relate to one another, those they serve, their communities and their partners. Specific tools, information, resources, training and support will help market-based organizations develop their own cultural styles while preserving the mission, values and visionary spirit of Catholic Health Initiatives’ foundresses.

**Feast Days Enhance Workplace Spirituality**

Based on the belief that truly spiritual people consistently combine action and contemplation in their daily routines, Catholic Health Initiatives suggested that market-based organizations observe three feast days each year — World Day of Healing (February 11), Founding of Catholic Health Initiatives (May 1) and Labor Day — to promote workplace spirituality. Market-based organizations and national offices were also encouraged to incorporate individual and group reflection into business meetings and work processes; and to provide occasional retreats that give staff time to reflect on goals and directions.

**Extensive Planning Assures Y2K Preparedness**

An enormous Year 2000 planning effort prepared Catholic Health Initiatives to maintain standards of patient care and continuity of operations in the event of Y2K-related failures. Market-based organizations developed detailed contingency plans that minimized risks by identifying alternative ways to perform clinical and business functions.

**Tragedy Underscores Compassion, Professionalism**

Catholic Health Initiatives’ market-based organization in Denver, Colo., showed extraordinary compassion and professionalism in caring for victims of the shooting at Columbine High School. Centura Health-St. Anthony Central Hospital staff treated victims of the tragedy, including four of the most seriously wounded students. Under crisis conditions, their dedication exemplified the true meaning of the healing ministry.

### Statistical Highlights

- **71 Hospitals**
- **49 Long-term care, assisted living facilities and residential units**
- **22 States: Arkansas, California, Colorado, Delaware, Idaho, Iowa, Kansas, Kentucky, Maryland, Minnesota, Missouri, Nebraska, New Jersey, New Mexico, North Dakota, Ohio, Oregon, Pennsylvania, South Dakota, Tennessee, Washington and Wisconsin**
- **72 Rural and urban communities**
- **$6 Billion in assets**
- **$5 Billion in annual operating revenues**
- Charity care as a percentage of net patient service revenue: **2.8%**
- Operations:
  - Acute inpatient days: **2,141,264**
  - Acute care admissions: **443,576**
  - Average acute care length of stay in days: **4.8**
  - Residential care days: **464,144**
  - Long-term care days: **1,259,543**
  - Assisted care days: **153,167**
- Outpatient revenues as a percentage of total revenues: **40.2%**
  - Approximately **75,000** full- and part-time employees
Sponsoring Congregations and Members

Benedictine Sisters of Mother of God Monastery
Watertown, South Dakota
Judith Fischer, OSB

Congregation of the Dominican Sisters of
St. Catherine of Siena of Kenosha, Inc.
Kenosha, Wisconsin
Susan Snyder, OP

Franciscan Sisters of Little Falls, Minnesota
Little Falls, Minnesota
Rita Kraemer, OSF

Nuns of the Third Order of St. Dominic
Great Bend, Kansas
Francine Schwarzenberger, OP

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Cincinnati, Ohio
Mary Ellen Murphy, SC

Sisters of Charity of Nazareth
Nazareth, Kentucky
Eleanor F. Martin, SCN

Sisters of the Holy Family of Nazareth
Philadelphia, Pennsylvania
Michaelann Delaney, CSFN

Sisters of Mercy of the Americas,
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Omaha, Nebraska
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Sisters of the Presentation of the Blessed Virgin Mary
Fargo, North Dakota
Mary Margaret Mooney, PBVM

Sisters of St. Francis of Colorado Springs
Colorado Springs, Colorado
Clarice Gentrup, OSF

Sisters of St. Francis of the Immaculate Heart of Mary
Hankinson, North Dakota
Ann Marie Friedrichs, OSF

Sisters of St. Francis of Philadelphia
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John F. DiCola
Senior Vice President Strategy and Business Development

Michael L. Fordyce
Chief Administrative Officer and Senior Vice President Human Resources

David J. Goode
Senior Vice President Operations

C. Kregg Hanson
Senior Vice President Operations

Geraldine M. Hoyler, CSC
Senior Vice President Finance and Treasury

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Senior Vice President and Chief Medical Officer

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M. Colleen Scanlon, RN, JD
Senior Vice President Advocacy

Daniel J. Sinnott
Senior Vice President Operations

Carolyn N. Ward
Senior Vice President Service Centers

David D. Zwickey
Interim Senior Vice President Continuum of Care
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Seated (from left): Amata Miller, IHM, PhD; Maryanna Coyle, SC; Patricia A. Cahill, JD

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Assistant Congregational Minister  
Sisters of St. Francis of Philadelphia  
Philadelphia, Pennsylvania

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Senior Vice President  
Clinical Integration  
Baylor Health Care System  
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Marjorie Beyers, PhD  
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President and Chief Executive Officer  
Ascension Health  
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President and Chief Executive Officer  
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School of Public Health and Community Medicine  
University of Washington  
Seattle, Washington
### MARKET-BASED ORGANIZATIONS AND FACILITIES

**As of July 1, 1999**

#### ARKANSAS
- St. Vincent Health System
  - Little Rock
  - St. Anthony Health Care Center
  - Morrilton
  - St. Vincent Doctors Hospital
  - Little Rock
  - St. Vincent Infirmary Medical Center
  - Little Rock
  - St. Vincent Medical Center/Sherwood
  - Sherwood
  - St. Vincent Rehabilitation Hospital
  - Sherwood

#### CALIFORNIA
- Our Lady of Fatima Villa
  - Saratoga

#### COLORADO
- Centura Health*
  - Englewood
    - Centura Senior Life Center
    - Denver
    - Gardens at St. Elizabeth
    - Denver
    - Medallion East
    - Colorado Springs
    - Medallion West
    - Colorado Springs
    - Namaste Alzheimer Center
    - Colorado Springs
    - Penrose Community Hospital
    - Colorado Springs
    - Penrose Hospital
    - Colorado Springs
    - Penrose-St. Francis Health Services
    - Colorado Springs
    - Progressive Care Center
    - Canon City
    - St. Anthony Central Hospital
    - Denver
    - St. Anthony North Hospital
    - Westminster
    - St. Francis Health Center
    - Colorado Springs
    - St. Joseph Manor
    - Florence
    - St. Mary-Corwin Medical Center
    - Pueblo
    - St. Thomas More Hospital
    - Canon City
    - The Villas at Sunny Acres
    - Denver
    - Villa Pueblo Towers
    - Pueblo
    - Mercy Medical Center
    - Durango

#### DELAWARE
- St. Francis Healthcare Services
  - Wilmington
    - St. Francis Care Center at Brackenridge
    - Owings
    - St. Francis Care Center at Wilmington
    - Wilmington
    - St. Francis Hospital
    - Wilmington

#### IDAHO
- Mercy Medical Center
  - Nampa
- Mountainside Care Center
  - Sandpoint

#### IOWA
- Mercy Health Network*
  - West Des Moines
    - Bishop Drumm Retirement Center
    - Johnston
    - House of Mercy
    - Des Moines
    - Mercy Clinics, Inc.
    - Des Moines
    - Mercy College of Health Sciences
    - Des Moines
    - Mercy Court
    - Des Moines
    - Mercy Medical Center - Centerville
    - Centerville
    - Mercy Medical Center - Des Moines
    - Des Moines
    - Mercy Park Apartments
    - Des Moines
    - Mercy Hospital
    - Coralville
      (part of Alegent Health, Omaha, Nebraska)
    - Mercy Hospital
    - Council Bluffs
      (part of Alegent Health, Omaha, Nebraska)

#### KANSAS
- Central Kansas Medical Center
  - Great Bend
    - Central Kansas Medical Center
    - Larned
- St. Catherine Hospital
  - Garden City
- St. John’s-Maude Norton Memorial Hospital
  - Columbus
    (as of October 1, 1999)
    - Columbus, Kansas

#### KENTUCKY
- CARITAS Health Services
  - Louisville
- CARITAS Home Care Services
  - Bardstown
- CARITAS Medical Center
  - Louisville
- CARITAS Peace Center
  - Louisville
- Flaget Memorial Hospital
  - Bardstown
- Marymount Medical Center
  - London
- Our Lady of the Way Hospital
  - Martin
- Saint Joseph Hospital
  - Lexington
    - Saint Joseph Hospital East
    - Lexington

#### MARYLAND
- St. Joseph Medical Center
  - Towson

#### MINNESOTA
- Lakewood Health Centers
  - Baudette
    - Warroad Care Center
    - Warroad
- St. Francis Home
  - Breckenridge
- St. Francis Medical Center
  - Breckenridge
- St. Joseph’s Area Health Services
  - Park Rapids
- Unity Family HealthCare
  - Little Falls
    - Albany Area Hospital and Medical Center
    - Albany
    - Alverna Apartments
    - Little Falls
    - St. Camillus Place
    - Little Falls
    - St. Gabriel’s Hospital
    - Little Falls
    - St. Otto’s Care Center
    - Little Falls

#### MISSOURI
- St. John’s Regional Medical Center
  - Joplin
- St. John’s Rehabilitation Center
  - Joplin
- Also includes St. John’s-Maude Norton Memorial Hospital
  - Columbus, Kansas
    (as of October 1, 1999)
<table>
<thead>
<tr>
<th>Location</th>
<th>Facility Name</th>
<th>City</th>
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<tbody>
<tr>
<td>Nebraska</td>
<td>Alegent Health*</td>
<td>Omaha</td>
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<tr>
<td></td>
<td>Alegent Health-Bergan Mercy Medical Center</td>
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<td></td>
<td>Mercy Care Center</td>
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</tr>
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<td></td>
<td>Also includes Mercy Hospital, Corning, Iowa, and</td>
<td></td>
</tr>
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<td></td>
<td>Mercy Hospital, Council Bluffs, Iowa</td>
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<td></td>
<td>Good Samaritan Health Systems</td>
<td>Kearney</td>
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<td>Richard H. Young Hospital</td>
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<td>Saint Elizabeth Health Systems</td>
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<td>Saint Francis Medical Center</td>
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<td></td>
<td>St. Mary's Hospital</td>
<td>Nebraska City</td>
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<td>New Jersey</td>
<td>St. Francis Medical Center</td>
<td>Trenton</td>
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<td>New Mexico</td>
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<td>St. Francis Gardens</td>
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<tr>
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<td>St. Joseph Medical Center</td>
<td>Albuquerque</td>
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<td>St. Joseph Northeast Heights Hospital</td>
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<tr>
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<td>St. Joseph Rehabilitation Hospital</td>
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<td></td>
<td>Mercy Medical Center</td>
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<td></td>
<td>Oakes Community Hospital</td>
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<td></td>
<td>St. Ansgar’s Health Center</td>
<td>Park River</td>
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<td></td>
<td>St. Joseph’s Hospital and Health Center</td>
<td>Dickinson</td>
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<td>Fargo</td>
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<td>Friendship, Inc.</td>
<td>Fargo</td>
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<td>Riverview Place</td>
<td>Fargo</td>
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<td>Ohio</td>
<td>Premier Health Partners*</td>
<td>Dayton</td>
</tr>
<tr>
<td></td>
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<td>Dayton</td>
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<td></td>
<td>The Maria-Joseph Center</td>
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<tr>
<td></td>
<td>TriHealth*</td>
<td>Cincinnati</td>
</tr>
<tr>
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<td>Roseburg</td>
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<td>Reading</td>
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<td></td>
<td>St. Joseph Medical Center</td>
<td>Reading</td>
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<td>St. Mary Medical Center</td>
<td>Langhorne</td>
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<td>South Dakota</td>
<td>St. Mary’s Healthcare Center</td>
<td>Pierre</td>
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<td>Gettysburg Medical Center</td>
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<td>Maryhouse Residential Nursing Facility</td>
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<td>Oahe Villa</td>
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<td>Parkwood Retirement Apartments</td>
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<td>Tennessee</td>
<td>Memorial Health Care System</td>
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<td>Memorial North Park Hospital</td>
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<td>Washington</td>
<td>Franciscan Health System</td>
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<td></td>
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<td></td>
<td>Care Center at Tacoma</td>
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<td>Wisconsin</td>
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<td>Merrill</td>
</tr>
<tr>
<td></td>
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<td>Good Samaritan Health Center</td>
</tr>
</tbody>
</table>

* Denotes joint operating agreement company. The facilities listed are Catholic Health Initiatives’ facilities included in the joint operating agreement.
...through love serve one another.

Galatians 5:13
Fiscal year 1999 was financially disappointing for Catholic Health Initiatives. The following consolidated financial statements show a net loss for the first time since Catholic Health Initiatives was formed in 1996. Operations were relatively unchanged compared to 1998, when Catholic Health Initiatives reported a net gain. Catholic Health Initiatives added two organizations in 1999: Saint Joseph Hospital East, Lexington, Ky., and Gettysburg Hospital, Gettysburg, S.D. Neither had a material impact on the financial position or results of Catholic Health Initiatives.

Utilization of services, as measured by both statistics and net revenues, was stable from 1998 to 1999, with acute admissions increasing only 1.7 percent. Although there were variations among facilities, the modest increase indicates that most of the Catholic Health Initiatives market-based organizations were able to retain market share. The average length of stay for acute admissions remained at 4.8 days despite increasing difficulties in the placement of Medicare beneficiaries with non-acute home health and skilled nursing providers.

The leadership of Catholic Health Initiatives is focused on restoration of essential balance sheet and operating performance positions during fiscal year 2000. Fiscal year 1999 financial statements were adversely affected by the federal Balanced Budget Act of 1997, most notably due to declining revenues from home health services and increases in unpaid Medicare costs. The impact of the Balanced Budget Act will continue as additional provisions of the law are implemented.
Consolidated Balance Sheet

The Catholic Health Initiatives balance sheet was weakened in 1999 by unfavorable operating performance. Total assets decreased $84 million. The greatest impact was on unrestricted cash and investments: days of total cash declined to 120 from 145 in 1998. Liquidity declined $214 million in 1999, a decrease of 12.2 percent, due to poor operating performance, funding of joint venture losses, expenditures for capital assets and pay-down of outstanding debt. Total investments, including those restricted for debt, insurance and donor requirements, were $1.7 billion.

Accounts receivable increased 4 percent in 1999, due in part to decreased collectability of self-pay patient accounts. Accounts receivable days, although higher than in 1998, were within industry norms. Reduction in the level of accounts receivable remains a significant goal throughout Catholic Health Initiatives.

Net property and equipment increased 4.5 percent in 1999. Capitalized asset additions were $458 million and another $25 million was invested in a joint venture for construction of a new patient care facility. In response to reduced operating performance, a capital freeze was established for certain market-based organizations at mid-year, with additional market-based organizations included as the fiscal year progressed.

Long-term debt, including the portion classified as current liabilities to be paid within the next fiscal year, was $1.7 billion in 1999, slightly less than in 1998. The 1999 debt-to-capitalization ratio was 33.5 percent, compared to the 34.6 percent ratio in 1998.

Consolidated Statement of Operations

Operating revenues increased 3.7 percent in 1999. Of $4.8 billion in net patient services revenue, 90 percent was attributable to traditional care services: 55 percent from acute inpatient services and 35 percent from outpatient services.

Operating expenses increased 8 percent in 1999 as market-based organizations were unable to match expenses with revenues. Expenses grew at a rate more than twice that of the growth in utilization and revenues. Compensation and benefits, which increased 6.3 percent, included $11.7 million for a non-cash pension adjustment required by Financial Accounting Standard (FAS) No. 87. The number of full-time equivalent employees increased 1.9 percent.

Supply expenses increased 4.2 percent despite concerted efforts to implement best practices for pharmaceuticals and other cost reductions. Depreciation and amortization increased 9.4 percent, reflecting significant growth in property and equipment during the past few years.

Interest expenses, down 2 percent from 1998 to $83 million, were favorably impacted by a reduction in outstanding debt and lower variable interest rates. The Catholic Health Initiatives intercompany borrowing rate for 1999 averaged 4.8 percent, approximately the same as the interest rate on external borrowing.

Bad debt expenses increased 22 percent in 1999 due to a number of computer conversions, reductions in Medicare bad debt payments mandated by the Balanced Budget Act and the write-off of certain long-term accounts receivable. Bad debts should remain relatively high due to increasing co-insurance and deductible payments transferred to patients by insurance plans. Further, payers continued to delay payments to providers, increasing the age of accounts.
General and administrative expenses, including purchased services, medical professional fees and consulting services, increased 13.6 percent in 1999. Part of the increase was due to a change in generally accepted accounting principles related to startup costs, which formerly were capitalized and now typically are expensed.

Catholic Health Initiatives incurred significant restructuring and impairment charges of $101 million in 1999, slightly less than in 1998. These included severance costs of $23 million, asset impairment charges of $53 million, a restructuring charge of $19 million and other charges of $6 million. The severance costs were incurred throughout Catholic Health Initiatives. The impairment charges of $53 million resulted from FAS No. 121, which requires a write-down of assets to reasonable value when it is clear that the results of historical performance or known future events will negatively impact an organization’s financial base. FAS 121 impairment charges were recorded at three market-based organizations during fiscal year 1999, and market-based organizations will continue to be scrutinized under this standard. The restructuring charge of $19 million reflected Centura Health’s assumption of debt for an unrelated entity, which had operated a physician-owned hospital, defaulted on debt payments and filed for bankruptcy protection. Centura Health negotiated terms of the debt repayment and received title to the property.

Minority interest, which recognizes the equity of minority partners in two ventures included in the organization’s financial statements, was positive due to the significant loss reported by Centura Health. Net non-operating gains included investment income of $69 million, net realized gains of $51 million, losses in unconsolidated subsidiaries of $47 million and other net gains of $10 million. Investment income was less than that of 1998, when the investment programs were restructured and significant gains were realized. Total return for the operating investment program was in line with expectations at 8.2 percent, compared to 14.7 percent in 1998. Half of the losses in unconsolidated subsidiaries were attributable to Medalia Healthcare, a physician practice joint venture. The Medalia physician practices were restructured in 1999, contributing $24 million to restructuring and operating losses for the market-based organization.

Conclusion

Fiscal year 1999 brought significant change to Catholic Health Initiatives. The movement from regional operations to a national ministry serving the needs of market-based organizations occurred at a time of significant change in the financial health of the industry. Catholic Health Initiatives has developed performance improvement plans for all market-based organizations that did not attain financial targets in 1999, and the capital freeze in effect at these organizations continued into fiscal 2000.

Catholic Health Initiatives has many demands on the stewardship of its resources. To continue the ministry in a vital manner, focus is being placed on strategic financial planning, analysis of results, improved operating performance and a stronger balance sheet.
Statement of Operations
(dollars in thousands)

<table>
<thead>
<tr>
<th>Description</th>
<th>1999</th>
<th>1998</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenues from patient services, net</td>
<td>$ 4,756,089</td>
<td>$ 4,587,324</td>
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<tr>
<td>Revenues from non-patient sources</td>
<td>409,198</td>
<td>393,483</td>
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<tr>
<td><strong>Total Revenues</strong></td>
<td>5,165,287</td>
<td>4,980,807</td>
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<tr>
<td>Compensation and benefits for employees and physicians</td>
<td>2,610,975</td>
<td>2,456,482</td>
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<tr>
<td>Supplies, maintenance, general and administrative</td>
<td>1,978,948</td>
<td>1,813,043</td>
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<td>Building and equipment depreciation</td>
<td>321,598</td>
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<td>Patient bad debts</td>
<td>210,999</td>
<td>173,135</td>
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<td>Interest on long-term debt</td>
<td>83,289</td>
<td>85,026</td>
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<tr>
<td><strong>Total Expenses</strong></td>
<td>5,205,809</td>
<td>4,821,735</td>
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<tr>
<td>Income (Loss) Before Restructuring and Impairment Charges</td>
<td>(40,522)</td>
<td>159,072</td>
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<tr>
<td>Restructuring and impairment charges</td>
<td>(100,884)</td>
<td>(109,402)</td>
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<td><strong>Income (Loss) After Restructuring and Impairment Charges</strong></td>
<td>(141,406)</td>
<td>49,670</td>
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<tr>
<td>Non-operating gains, net</td>
<td>83,324</td>
<td>190,597</td>
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<td>Minority partner interest in affiliated entities</td>
<td>4,312</td>
<td>(3,000)</td>
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<td><strong>Excess (Deficit) of Revenues Over Expenses</strong></td>
<td>(53,770)</td>
<td>237,267</td>
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Benefits for the Poor and the Broader Community  
(dollars in thousands)  

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<tr>
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<tr>
<td>Traditional charity care costs</td>
<td>$74,483</td>
<td>$66,445</td>
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<tr>
<td>Unpaid costs of Medicaid and other indigent care programs</td>
<td>79,091</td>
<td>59,394</td>
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<tr>
<td>Non-billed services for the poor</td>
<td>3,474</td>
<td>6,423</td>
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<tr>
<td>Cash and in-kind donations</td>
<td>4,483</td>
<td>6,988</td>
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<td>Other benefits to the poor</td>
<td>9,572</td>
<td>14,925</td>
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<td>171,103</td>
<td>154,175</td>
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Measurable Benefits for the Poor

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<thead>
<tr>
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<tbody>
<tr>
<td>Unpaid costs of Medicare and other senior programs</td>
<td>291,504</td>
<td>213,557</td>
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<td>Non-billed services for the community</td>
<td>19,974</td>
<td>14,586</td>
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<td>Education and research</td>
<td>18,070</td>
<td>18,087</td>
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<td>Other community benefits</td>
<td>19,253</td>
<td>14,102</td>
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<td>348,801</td>
<td>260,332</td>
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Total Measurable Benefits for the Poor and the Broader Community

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<tr>
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<td>519,904</td>
<td>414,507</td>
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(Total measurable benefits for the poor and the broader community were 10.1 percent and 8.3 percent of total operating revenues for the fiscal years ended June 30, 1999 and 1998, respectively.)

Statistical Highlights

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<thead>
<tr>
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<th>1999</th>
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<tr>
<td>Acute inpatient days</td>
<td>2,141,264</td>
<td>2,076,495</td>
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<td>Acute care admissions</td>
<td>443,576</td>
<td>436,139</td>
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<td>Average acute care length of stay in days</td>
<td>4.8</td>
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<td>Residential care days</td>
<td>464,144</td>
<td>438,917</td>
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<td>Long-term care days</td>
<td>1,259,543</td>
<td>1,203,660</td>
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<td>Assisted care days</td>
<td>153,167</td>
<td>137,034</td>
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<td>Outpatient revenues as a percentage of total revenues</td>
<td>40.2%</td>
<td>40.3%</td>
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<td>Number of full-time employee equivalents</td>
<td>58,327</td>
<td>57,250</td>
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