CATHOLIC HEALTH INITIATIVES
2001 ANNUAL REPORT

Continuing the spirit and legacy

THE FIRST FIVE YEARS
Two people who enjoy the care provided at Franciscan Villa, South Milwaukee, Wis., resident Woody Balaas and daycare participant Alexa Mayer.
Catholic Health Initiatives will

continue the compassionate tradition

of Catholic health care into the next

century and the next millennium.

Much will change, but the sponsors...

and all who contributed so much to

the original predecessor systems know

that what they have built together

will endure in many communities

as Catholic Health Initiatives.

Excerpt from A Report on the Creation of Catholic Health Initiatives, 1996
DEAR CATHOLIC HEALTH INITIATIVES
FAMILY, PARTNERS AND FRIENDS:

Catholic Health Initiatives is now five years old and what a thrilling journey it has been. To see this organization go from dream to reality has been a great privilege.

Today, Catholic Health Initiatives is not only surviving, but thriving—a testament to the vision of those who worked long and hard to create this organization. These visionaries were leaders of Catholic Health Initiatives’ participating congregations and predecessor health systems. They displayed a selfless commitment to building a new kind of system with a unique model of religious and lay sponsorship. We were grateful when many of the people who played a role in the creation of Catholic Health Initiatives were able to gather for a fifth anniversary celebration in Denver in June 2001.

It is important to remember the beginning of Catholic Health Initiatives and to honor its deep roots in the tradition of Catholic health care, yet we also look forward to an exciting future. In just five years, Catholic Health Initiatives has established a number of hallmarks, which include clinical and service quality, the building of healthy communities, improvement in operating and
financial performance; a commitment to advocacy; and thoughtful strategic planning. You will learn more about the achievements of Catholic Health Initiatives in each of these areas within this report.

As we move into a challenging future for health care and for Catholic Health Initiatives, we must remember those whose risk-taking enabled this organization to be where it is today. We recall the women religious who bravely entered the Catholic health ministry many years ago with the most basic of tools, but hearts full of compassion. To continue their spirit and legacy through Catholic Health Initiatives is the best, most lasting recognition we can provide to them.

Maryanna Coyle, SC

Maryanna Coyle, SC
Chair Board of Stewardship Trustees

Patricia A. Cahill, JD
President and Chief Executive Officer
"Catholic Health Initiatives accepts its diversity as a ‘laboratory for quality.’ It provides a unique opportunity for the organization to continue to identify best practices, disseminate results and establish accountability for quality by integrating resources across the system.”

Harold Ray, MD, Chief Medical Officer

Harold Ray, MD, chief medical officer for Catholic Health Initiatives, led the system-wide team that developed the winning application for the 2001 National Quality Healthcare Award. The application described Catholic Health Initiatives’ multifaceted quality journey, which includes leadership commitment, performance management, outcomes reporting and the creation of healthy communities.
Catholic Health Initiatives' fifth anniversary year was a banner year for quality. In April 2001, the organization won the prestigious National Quality Health Care Award, presented annually by the National Committee for Quality Health Care and Modern Healthcare magazine. The award recognizes Catholic Health Initiatives as a provider whose demonstrated goal is to improve health care through performance and leadership.

- Catholic Health Initiatives' commitment to quality continued with a focus on the reduction of medical errors—particularly medication errors—through the work of its National Patient Safety Task Force and National Pharmacy Program. All market-based organizations have implemented proven pharmacy best practices to reduce adverse drug events and medication errors.

- The market-based organizations within Catholic Health Initiatives shared their best quality practices through internal publications like Innovative Projects to Improve Outcomes, leadership orientation programs and telephone forums for nurse executives and leaders responsible for patient satisfaction.

- The Catholic Health Initiatives Nurse Executive Advisory Council pointed the organization toward new methods of patient care delivery and new models of caregiver training to deal with an issue that impacts quality—the shortage of nurses, which is projected to peak in 2007.

- To help develop the skills and job satisfaction of nurses and other caregivers, Catholic Health Initiatives is implementing a National Clinical Competency Program, which gauges clinical competence and makes recommendations for training and professional development. More than 200 nurses have been assessed at an initial group of four market-based organizations: Memorial Health Care System, Chattanooga, Tenn.; Saint Joseph Hospital, Lexington, Ky.; St. John's Regional Medical Center, Joplin, Mo.; and St. Joseph Medical Center, Reading, Pa.
Continuous Improvement in Customer Satisfaction

Catholic Health Initiatives' rigorous customer satisfaction program enables market-based organizations to track performance over time and identify best practices. Survey results drive improvement in the satisfaction of core customer groups, including patients who utilize inpatient, maternity, same day surgery, outpatient surgery and emergency services.

Customer Satisfaction Results

<table>
<thead>
<tr>
<th>Percent of Market-based Organizations with Improvement in Overall Quality</th>
<th>Percent of Market-based Organizations with Improvement in Satisfaction of Multiple Customer Groups</th>
<th>Percent of Market-based Organizations with Improvement in Satisfaction of at Least One Customer Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>12%</td>
<td>15%</td>
<td>28%</td>
</tr>
<tr>
<td>22%</td>
<td>27%</td>
<td>58%</td>
</tr>
</tbody>
</table>

Fiscal Year 2000  Fiscal Year 2001

Hospitals Honored for Excellence in Quality, Efficiency and Performance

Several of Catholic Health Initiatives' market-based organizations ranked among the nation's best according to the 100 Top Hospitals™ studies conducted by the health care data firm Solucient during 2001. The honored hospitals include:

- Good Samaritan Hospital, Dayton, Ohio, for overall quality and efficiency
- Memorial Hospital, Chattanooga, Tenn., for cardiac services
- Nazareth Hospital, Philadelphia, Pa., for intensive care services
- St. Francis Hospital, Federal Way, Wash., for overall quality and efficiency
- St. Francis Hospital, Wilmington, Del., for intensive care services
- Saint Joseph Hospital, Lexington, Ky., for cardiac services, orthopedic services and stroke services

“Quality is as much about the way we provide care as it is about the outcome of the care we provide.”

Kevin Fickenscher, MD
Catholic Health Initiatives Board of Stewardship Trustees
"There was not a detailed vision for the Mission and Ministry Fund, other than we wanted to challenge the boundaries of institutional care. We see wonderful things happening as a result of these grants."

Peggy Martin, OP, JCL, Senior Vice President, Sponsorship and Governance.

Peggy Martin, OP, JCL, senior vice president of sponsorship and governance (left) and Peggy Egan, OSF, PhD, vice president of mission and healthy communities, lead Catholic Health Initiatives' vision of healthy communities. At Lake Middle School in the inner city of Denver, Colo., Centura Health-St. Anthony Hospitals operates a school-based health center that serves more than 85 percent of the student population. This health center, and another at nearby Cheltenham Elementary School, was established with the help of two grants from the Catholic Health Initiatives Mission and Ministry Fund.
The creation of healthy communities has always been a vital part of the Catholic Health Initiatives mission, vision and growth as a system. When the organization was formed in 1996, one of the first orders of business was to establish the Mission and Ministry Fund, which provides grants to organizations and collaborative groups that reach beyond the acute care medical model to promote healthy communities.

- In fiscal year 2001, Catholic Health Initiatives presented more than $1.7 million in healthy community project and planning grants from the Mission and Ministry Fund. The grants continue to enable new healthy community collaborations to take root and help mature collaborations expand or diversify their efforts.

- Catholic Health Initiatives also channels financial resources to the creation of healthy communities through its Direct Community Investment Program. The program provides no-interest or low-interest loans to organizations that make housing, jobs, education and health care more accessible to low-income and minority populations. The program has loaned a total of $15 million to 24 organizations, including many in communities served by market-based organizations, such as Louisville, Ky.; Baudette, Minn.; and Albuquerque,

- N.M. During fiscal year 2001, loans also went to the Chicago Community Loan Fund, which serves distressed communities in Chicago, Ill.; Fonkoze, a non-profit loan fund that lends money to the poorest people in Haiti; and SosteNica, a loan fund that focuses on sustainable community development in Nicaragua.

- Catholic Health Initiatives also builds healthy communities internationally as a member of the Catholic Consortium for International Health Services. The consortium is a clearinghouse for the identification and sharing of projects and information that can strengthen its members' international mission work. The group has shipped thousands of pounds of medical supplies to Third World countries. Catholic Health Initiatives is participating in projects to provide training in end-of-life care at a hospital in Croatia and to expand the capabilities of a hospital laboratory in Cameroon.
"The way in which health care interfaces with local communities to build a healthy future depends upon the leadership of the health care deliverers and the leadership of the local communities. Because of the variables in leadership and in the needs of the communities, Catholic Health Initiatives knows that no one model of healthy communities fits all."

Madonna Marie Cunningham, OSF
Member of the Catholic Health Initiatives Founding Steering Council (1995–1996)

Funding new ministries during Catholic Health Initiatives' first five years, the Mission and Ministry Fund presented: 102 grants worth more than $9 million to 71 organizations.
It takes a diverse group of leaders to make this Baltimore neighborhood thrive. (Back row, left to right) Margaret Locklear, Barbara Aylesworth, Florence Hee, OSF, and Diane Jones. (Front row, left to right) Melvin Freeman, Richard Packie and Nichole Jones.

Action in the Neighborhood

A spate of drug-related murders rocked the Blair-Edison neighborhood in Baltimore, Md., and sparked the formation of the Blair-Edison Healthy Community Coalition. Through St. Joseph Medical Center in Towson, Md., the coalition received one of the first Healthy Community Planning Grants presented by the Catholic Health Initiatives Mission and Ministry Fund. Key players in the coalition are coached by Diane Jones, director of internal and executive communication for Catholic Health Initiatives and a member of the Healthy Communities Task Force. The coalition is determined to build on the community’s assets, including its status as one of only five racially integrated Baltimore neighborhoods in which more than 75 percent of homes are owner-occupied. “We are thrilled to be actively involved in this vital neighborhood effort,” said Anne Patrice Hefner, OSF, vice president of mission and ministry at St. Joseph.
"We have an important mission, and we have to run our business well in order to carry out our mission."

Gary Rowe, President and Chief Executive Officer, St. John's Regional Medical Center, Joplin, Mo.

THE TURNAROUND TRACK

In November 1998, Gary Rowe (left) became president and chief executive officer of St. John's Regional Medical Center, Joplin, Mo. The market-based organization's financial health was rapidly deteriorating, and it would miss its fiscal year 1999 budget by $34 million with actual losses of $26 million. Rowe put the organization on a turnaround path. Through a multifaceted effort—which included balance sheet analysis, rate adjustments, cost reductions, reorganization of management, open communications with physicians and new marketing programs—St. John's has recovered well, posting a net operating profit of $12 million for fiscal year 2001. Kevin Lofton (right), executive vice president and chief operating officer for Catholic Health Initiatives, introduced performance management to Catholic Health Initiatives in 1999 to provide additional support and resources that help senior vice presidents of operations and market-based organizations improve operating performance.
THE FIFTH YEAR OF
OPERATING PERFORMANCE IMPROVEMENT

Improving operating and financial performance became a top goal of Catholic Health Initiatives in 1999. As Catholic Health Initiatives marked its fifth anniversary in 2001, several market-based organizations celebrated improved operating performance made possible by strong market-based and senior operations leadership and Catholic Health Initiatives' performance management services. Stronger operating and financial performance enables market-based organizations to better serve their communities.

- During fiscal year 2001, through cost containment and increased pharmacist involvement in patient care, the National Pharmacy Program achieved $9.9 million in savings, exceeding its goal of $3.5 million. Through astute management of the clinical equipment life cycle, the Clinical Engineering Program saved $6.8 million.

- Market-based organizations reduced the losses associated with owned physician practices from $75 million during fiscal year 2000 to $56 million during fiscal year 2001 with the help of Catholic Health Initiatives' Management Assistance Clinic Break Even Team (also known as the "Madethi" Team).

- The structured approach created by a national program office has put market-based organizations on track for compliance with the data interchange and privacy regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

- Catholic Health Initiatives continued to streamline its national organization, consolidating its Cincinnati, Ohio, and Louisville, Ky., offices in a new location in Erlanger, Ky., and closing national offices in Omaha, Neb., Tacoma, Wash., and Colorado Springs, Colo.
Financial Journey

Catholic Health Initiatives reported strong operating and financial performance in fiscal year 2001. During the past five years, benefits for the poor and the broader community have shown strong year-to-year growth.

Catholic Health Initiatives Financial Results
"There are aspects of St. Vincent's current turnaround that we could not accomplish without Catholic Health Initiatives.

The performance management team doesn't just look over our shoulders, but gives us access to the expertise and support we need to make the changes that we have to make. We're still working to get stronger, and we expect the Catholic Health Initiatives performance management program to take us to the next level of improvement."

Stephen Marsfield, President and Chief Executive Officer, St. Vincent Health System, Little Rock, Ark.

Diversity in Approaches to Customer Satisfaction

The 18 market-based organizations that scored significantly higher than the system-wide average for customer satisfaction during fiscal year 2001 have their own approaches to caring for customers. Some use structured initiatives to ensure the satisfaction of patients and their families, employees and physicians, while others view customer satisfaction as a natural outcome of their compassionate approach to patient care. Top performers in customer satisfaction include:

- Albany Area Hospital and Medical Center, Albany, Minn.
- Carrington Health Center, Carrington, N.D.
- Flaget Memorial Hospital, Bardstown, Ky.
- Good Samaritan Health Systems, Kearney, Neb.
- Holy Rosary Medical Center, Ontario, Ore.
- Lakewood Health Center, Baudette, Minn.
- Memorial Hospital, Chattanooga, Tenn.
- Memorial North Park Hospital, Hixson, Tenn.
- Mercy Hospital, Valley City, N.D.
- Mercy Medical Center, Roseburg, Ore.
- Mercy Medical Center, Williston, N.D.
- Saint Elizabeth Regional Medical Center, Lincoln, Neb.
- Saint Francis Medical Center, Grand Island, Neb.
- Saint Joseph Hospital, Lexington, Ky
- St. Clare Hospital, Lakewood, Wash.
- St. John's Regional Medical Center, Joplin, Mo.
- St. Joseph Medical Center, Tacoma, Wash.
- St. Joseph Medical Center, Towson, Md.
Catholic Health Initiatives believes that advocacy starts at the community level. Through its Mission and Ministry Fund grants and Direct Community Investment Program, the organization has provided hundreds of local communities in the United States and abroad with the means to mobilize grassroots efforts to achieve greater social justice.

Advocacy is so central to the mission and vision of Catholic Health Initiatives that one of the organization’s core strategies is to be a national leader in advocacy for social justice and systemic change. Colleen Scanlon, RN, JD, senior vice president of advocacy for Catholic Health Initiatives, regularly takes the organization’s advocacy agenda directly to the halls of Congress.
Catholic Health Initiatives advances its health care ministry through mission awareness, advocacy, lived spirituality and the creation of new ministries. All of these efforts call on the organization’s national and market-based leaders to fully utilize their management skills, courage, diplomacy and faith.

- More than 75 percent of Catholic Health Initiatives’ market-based organizations communicated with their members of Congress through meetings, letters, e-mails and phone calls. Many participated in the Catholic Health Association and American Hospital Association annual legislative meetings in Washington, D.C., to discuss priority health care issues with congressional leaders.

- As part of its commitment to socially responsible investing, Catholic Health Initiatives entered the arena of shareholder activism and co-filed several shareholder resolutions during fiscal year 2001. The resolutions asked pharmaceutical firms to adopt price restraint policies and tobacco companies to ensure that their advertising is not designed to appeal to teenagers.

- Catholic Health Initiatives has conducted in-depth mission assessments at all market-based organizations, revealing a wealth of best practices in core values integration, spirituality in the workplace, care for those who are poor and other mission-related activities. The assessments also identified areas of opportunity, such as ethics, workplace diversity and healthy communities.

- Catholic Health Initiatives published its second collection of Sacred Stories, in which staff members, leaders, volunteers, physicians and others within Catholic Health Initiatives share their stories of spirituality at work.
A New Ministry

The Catholic health ministry in Lancaster, Pa., carries on through a new type of market-based organization, St. Joseph Health Ministries, ever since Catholic Health Initiatives found a new owner for the former St. Joseph Hospital. Funded by a portion of the proceeds of the sale, St. Joseph Health Ministries continues many of the community-based health and wellness programs established by the hospital. First led by John Tolmie (right), who is now the president and chief executive officer of St. Joseph Medical Center in Towson, Md., St. Joseph Health Ministries is expanding its multi-generational services under the leadership of Jennifer Thompson (left), executive director. “In their communications, the staff is always very clear that St. Joseph Health Ministries is not another social service agency, but a ministry of health and healing,” said Peggy Egan, OSF, PhD, vice president of mission and healthy communities for Catholic Health Initiatives. "That identity will serve them well as they grow in ways that will meet the needs of the community.”
“St. Joseph Health Ministries’ purpose is to continue and to expand a variety of services that will positively impact the health of the community.

For example, we are committed to working with local parishes to provide services and resources that will help them become healthier communities. Our ministries reach out to all age groups and individuals with varied needs.”

Jennifer Thompson, Executive Director, St. Joseph Health Ministries, Lancaster, Pa.
Catholic Health Initiatives' 2001 strategic planning process engaged more stakeholders than ever before. The steering committee formed to update the existing strategic plan included members of the Board of Stewardship Trustees, the senior management leadership team, resource groups and market-based chief executive officers (left to right): Peter Jacobson, St. Joseph's Area Health Services, Park Rapids, Minn.; Michael Gloor, Saint Francis Medical Center, Grand Island, Neb.; Bruce Klockars, Flaget Memorial Hospital, Bardstown, Ky.; John Morahan, St. Joseph Medical Center, Reading, Pa.; Joseph Wilczek, Franciscan Health System, Tacoma, Wash.; and David Veilinga, Mercy Medical Center, Des Moines, Iowa.

THE FIFTH YEAR OF

Strategic Development

Based on stakeholder research and a new environmental assessment, Catholic Health Initiatives began to update its strategic plan in its fifth anniversary year. The new plan, which will guide the organization through the 2007 fiscal year, will pay special attention to four critical planning issues: quality, people, growth and performance.

- The new strategic plan includes a set of updated core strategies and objectives for Catholic Health Initiatives.
- To give market-based and national staff greater ability to capture, organize, store and retrieve information across the organization, Catholic Health Initiatives began to create a technology-based infrastructure for knowledge management.
"Considering all the challenges that Catholic Health Initiatives has come through, such as improving operating performance and creating a greater sense of 'systemness,' it's the right time to focus on the future."

John DiCola, Senior Vice President, Strategy and Business Development
“During its first five years, Catholic Health Initiatives, while responding to the complex issues and challenges of the current health care environment in the United States, initiated a strategic planning process that is innovative, collaborative and directional for the future.”

Esther Anderson, OSF, PhD
Catholic Health Initiatives Board of Stewardship Trustees

Strategic Capital Investment

To ensure that capital funding commitment matches its priorities and capacity, Catholic Health Initiatives developed an integrated strategic and financial planning process. Catholic Health Initiatives is experiencing increased demand for strategic capital investment to build additional program and service capacity. As part of the planning process, Catholic Health Initiatives’ market-based organizations develop and submit master facility plans for large-scale renovation or construction projects. A master facility plan template developed by Catholic Health Initiatives helps market-based organizations work through every detail of a proposed project, including all strategic and operational implications.
### Statistical Highlights
**As of June 30, 2001**

<table>
<thead>
<tr>
<th><strong>64</strong> Hospitals</th>
<th><strong>Operations</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>45</strong> Long-term care, assisted living facilities and residential units</td>
<td>Acute inpatient days: <strong>2,141,126</strong></td>
</tr>
<tr>
<td><strong>1</strong> Community-based health ministry</td>
<td>Acute care admissions: <strong>455,717</strong></td>
</tr>
<tr>
<td><strong>21</strong> States: Arkansas, California, Colorado, Idaho, Iowa, Kansas, Kentucky, Maryland, Minnesota, Missouri, Nebraska, New Jersey, New Mexico, North Dakota, Ohio, Oregon, Pennsylvania, South Dakota, Tennessee, Washington and Wisconsin</td>
<td>Average acute care length of stay in days: <strong>4.7</strong></td>
</tr>
<tr>
<td><strong>66</strong> Rural and urban communities</td>
<td>Acute inpatient revenues as a percentage of revenues from patient services: <strong>51.4%</strong></td>
</tr>
<tr>
<td><strong>$6.4</strong> Billion in assets</td>
<td>Long-term care days: <strong>1,240,126</strong></td>
</tr>
<tr>
<td><strong>$5.7</strong> Billion in annual revenues</td>
<td>Approximately <strong>67,000</strong> full- and part-time employees</td>
</tr>
</tbody>
</table>

Charity care as a percentage of revenues from patient services: **3.3%**

Quantifiable community benefit (provided to the poor and broader community) as a percentage of total revenues: **11%**

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2001 Annual Report
Catholic Health Initiatives

Board of Stewardship Trustees

Back Row (left to right):
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Elizabeth Wendelin, SCN
Donald A. Brennan
Kevin M. Fickenscher
Robert B. Johnson
John F. Anderson
Fred Kammer, SJ

Middle Row (left to right):
Esther Anderson, OSF
Marjorie Beyers
Amata Miller, IHM
Karin J. Dufault, SP
Patricia J. McDermott, RSM

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Maryanna Coyle, SC
Kathryn M. Merson

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The College of St. Catherine
St. Paul, Minnesota

Elizabeth Wendelin, SCN
Director of Parish Leadership
Diocese of Lexington
Lexington, Kentucky

Howard S. Zuckerman, PhD
Sequim, Washington
**Participating 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
  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

- Sisters of Charity of Cincinnati
  Cincinnati, Ohio
  Mary Ellen Murphy, SC

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

- Sisters of the Holy Family of Nazareth
  Philadelphia, Pennsylvania
  Celine Warnick, CSFN

- Sisters of Mercy of the Americas, Regional Community of Omaha
  Omaha, Nebraska
  Patricia Forret, RSM

- Sisters of the Presentation of the Blessed Virgin Mary
  Fargo, North Dakota
  Maureen Walker, PBVM

- Sisters of St. Francis of Colorado Springs
  Colorado Springs, Colorado
  Clarice Gertrup, OSF

- Sisters of St. Francis of the Immaculate Heart of Mary
  Hankinson, North Dakota
  Rebecca Metzger, OSF

- Sisters of St. Francis of Philadelphia
  Philadelphia, Pennsylvania
  Anita Cattafesta, OSF

**Senior Management Leadership Team**

- Patricia A. Cahill, JD
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- Kevin E. Lofton
  Executive Vice President and Chief Operating Officer
- Michael L. Fordyce
  Chief Administrative Officer
- Diana G. Bader, OP, PhD
  Senior Vice President of Mission
- Ruth W. Brinkley
  Senior Vice President of Performance Management
- John F. DiCola
  Senior Vice President of Strategy and Business Development
- David J. Goode
  Senior Vice President of Operations
- Geraldine M. Hoyler, CSC
  Senior Vice President of Finance and Treasury
- James R. Kaskie
  Senior Vice President of Operations
- Deborah M. Lee-Eddie
  Senior Vice President of Operations
- Christopher J. Macmanus
  Senior Vice President of Information Technology and Chief Information Officer
- Peggy Ann Martin, OP, JCL
  Senior Vice President of Sponsorship and Governance
- Phillip W. Mears
  Vice President of Supply Chain Management
- Mitch H. Melfi, Esq.
  Senior Vice President and Chief Risk Officer
- Paul G. Neumann, Esq.
  Senior Vice President of Legal Services and General Counsel
- Harold E. Ray, MD
  Senior Vice President and Chief Medical Officer
- Joyce M. Ross
  Senior Vice President of Communications
- M. Colleen Scanlon, RN, JD
  Senior Vice President of Advocacy
- Larry A. Schulz
  Senior Vice President of Operations
- David D. Zwickey
  Senior Vice President of Continuum of Care
Catholic Health Initiatives

Market-Based Organizations and Facilities

As of June 30, 2001

ARKANSAS
St. Vincent
Health System
Little Rock
Stephen L. Mansfield
President and CEO

Includes:
St. Vincent Doctors Hospital
Little Rock
Karen Statham
Administrator
St. Vincent Infirmary Medical Center
Little Rock
Karen Haynes
Administrator
St. Vincent Medical Center/Sherwood
Sherwood
John Nutter
Interim Administrator
St. Vincent Rehabilitation Hospital
Sherwood
Jason Spring
Administrator

Includes:
St. Anthony Health Care Center
Monroe
Johnson L. Smith
CEO and Administrator

CALIFORNIA
Our Lady of Fatima Villa
Saratoga
Preston H. Winzer
CEO

COLORADO
Centura Health
Englewood
Joseph R. Swedberg
President and CEO

Centura Health is a joint operating agreement between Catholic Health Initiatives and Portocare Adventist Health Care in Colorado to manage facilities including those listed below:

Centura Senior Life Center
Denver
Bruce Russell
Administrator
Gardners at St. Elizabeth
Denver
Beth Brennan
Administrator
Perricone-Stephens Health Services
Colorado Springs
Rick O'Connell
Administrator

IDAHO
Mercy Medical Center
Nampa
Joseph Messmer
President and CEO

IOWA
Mercy Health Network
Des Moines
David Vellinga
Chair, Management Committee

Mercy Health Network is a joint operating organization created by Catholic Health Initiatives and Trinity Health to manage facilities in Iowa including those listed below:

Bishop Drumm Retirement Center
Johnston
Brian E. Farrar
President and CEO

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
William C. Assel
President and CEO
Mercy Medical Center—Des Moines
Des Moines
David Vellinga
President and CEO
Mercy Park
Des Moines

MERRILL

MINNESOTA
LakeWood Health Center
Baudette
Shara Ray Paul
President and CEO
St. Francis Medical Center
Breckenridge
David A. Nelson
President and CEO

St. Francis Home
Breckenridge
David A. Nelson
Administrator
St. Joseph's Area Health Services
Park Rapids
Peter Jacobson
President and CEO
Unity Family Healthcare
Little Falls
Carl Vaugner
President and CEO

Includes:
Albany Area Hospital
Albany
Ben Koppelman
Administrator
Alverna Apartments
Little Falls
Mark Koepmeier
Housing Manager
St. Camillus Place
Little Falls
St. Otto's Care Center
Little Falls
Cory Glad
Administrator

MISSOURI
St. John's Regional Medical Center
Joplin
Gary L. Rowe
President and CEO

Includes:
Maude Norton Memorial Hospital
Columbia, Kansas
St. John's Rehabilitation Center
Joplin
Gary L. Rowe
President and CEO

MONTANA
Alegent Health
Omaha
Charles J. Marr
Chief Executive Officer

NEBRASKA
Alegent Health
Omaha
Charles J. Marr
Chief Executive Officer

* Returned to the Congregation of the Dominican Sisters of St. Catherine of Siena of Kansas, Wis., October 2001.
Alegent Health is a joint operating agreement between Catholic Health Initiatives and Immanuel Healthcare System, which is affiliated with the Nebraska Synod of the Evangelical Lutheran Church. Alegent Health manages facilities including those listed below:

Alegent Health-
Bergan Mercy Medical Center
Omaha
Charles J. Marr
Chief Executive Officer

Mercy Care Center
Omaha
Deb Walker
Operations Leader

Mercy Hospital
Corning, Iowa
James C. Ruppert
Administrator

Mercy Hospital
Council Bluffs, Iowa
Charles J. Marr
Chief Executive Officer

Good Samaritan Health Systems
 Kearney
Kenneth Tomlin
President and CEO

Includes:
Richard H. Young Hospital
Kearney
William Grobott
Administrator

Saint Elizabeth Health Systems
Lincoln
Robert J. Lank
President and CEO

Includes:
Saint Elizabeth Regional Medical Center
Lincoln
Robert J. Lank
President and CEO

Saint Francis Medical Center
Grand Island
Michael R. Goor
President and CEO

St. Mary's Hospital
Grand Island
Daniel J. Kelly
President and CEO

NEW MEXICO
St. Joseph Healthcare System
Albuquerque
Arthur Dunn
Interim President and CEO

Includes:
St. Joseph Medical Center
Dona Ana County
Arthur Dunn
Interim President and CEO

St. Joseph Northeast
Albuquerque
Arthur Dunn
Interim President and CEO

St. Joseph Rehabilitation
Albuquerque
Mary Lou Coors
Administrator

St. Joseph West
Mesa Hospital
Albuquerque
Arthur Dunn
Interim President and CEO

NORTH DAKOTA
Carrington Health Center
Carrington
Marshall Sterle
Interim President and CEO

Mercy Hospital
Dawson
Mary Lou Coors
Administrator

Mercy Hospital Valley City
Jane Bartel
President and CEO

Mercy Medical Center Williston
James Cheever
Interim President and CEO

Oakes Community Hospital
Oakes
Bradley D. Burns
President and CEO

St. Joseph's Hospital and Health Center
Dickinson
Greg V. Hanson
President and CEO

Villa Nazareth
Corporation
Fargo
Jeff L. Pederson
President and CEO

NEW JERSEY
St. Francis Medical Center
Trenton
Judith M. Persichilli
President and CEO

Includes:
Friendship, Inc
Fargo
Jeff L. Pederson
President and CEO

RiverView Place
Fargo
Jenny Urogen
President and CEO

OHIO
Premier Health Partners
Dayton
Thomas Breitenbach
President and CEO

Premier Health Partners is a joint operating agreement between Catholic Health Initiatives and MedAmerica Health Systems Corporation to manage facilities including those listed below:

Good Samaritan Hospital
Dayton
K. Douglas Beck
President and CEO

The Maria Center
Dayton
Bonnie G. Landon
President and CEO

TriHealth
Cincinnati
John S. Prout
President and CEO

TriHealth is a joint operating agreement between Catholic Health Initiatives and Bethesda, Inc. Cincinnati to manage facilities including those listed below:

Good Samaritan Hospital
Cincinnati
John S. Prout
President and CEO

OREGON
Holy Rosary Medical Center
Portland
Bruce Hopkins
President and CEO

Mercy Healthcare, Inc
Portland
Victor J. Trescone
President and CEO

SOUTH DAKOTA
St. Mary’s Healthcare Center
Sioux Falls
Pierre
James D. M. Russell
President and CEO

Includes:
Gettysburg Medical Center
Gettysburg
Mark Schmidt
President and CEO

WISCONSIN
Franciscan Villa
South Milwaukee
Roger L. DeMark
President and CEO

Good Samaritan Health Center
Merrill
Michael Hammer
President and CEO
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.

Vision

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

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.
2001 Financial Report

Financial report

Catholic Health Initiatives
INTRODUCTION


The favorable margin was accomplished despite a weak investment environment in the overall economy and losses from the transfers of certain market-based organizations to other sponsors. Before investment income the excess margin was 1.3 percent, which was significantly above the prior fiscal year's deficit margin of 1.5 percent.

Fiscal year 2001 brought many changes, the most notable being the transfer of sponsorship of four market-based organizations to Catholic Health East on June 30, 2001. The transfer of a fifth market-based organization, in Trenton, N.J., was not completed until December 31, 2001, due to a delay in the state regulatory processes. A sixth market-based organization, in Park River, N.D., was transferred to the community on December 31, 2000. The loss on sponsorship transfers was $48 million, which was included in restructuring and impairment charges. In accordance with generally accepted accounting principles, the consolidated audited financial statements included the operations and statistics of the transferred market-based organizations through the effective dates of transfer, but not the related balance sheets.
BALANCE SHEET
As a result of the sponsorship transfers, total assets decreased slightly in fiscal year 2001 compared to the prior year. However, key liquidity and leverage ratios improved significantly. Days of total cash were 164 as of June 30, 2001, a significant increase from 142 days at the prior year-end. If the operations of the transferred market-based organizations had been excluded, days of total cash would have been 176 at June 30, 2001.

Due to the sponsorship transfers, there was a 9 percent decrease in current assets in fiscal year 2001 compared to the prior year. Most of the decrease was due to the transfer of accounts receivable, which was offset by increases in cash and other current assets. The number of days of patient revenues in patient accounts receivable decreased to 58 from 65 at the prior year-end, evidence of the significant focus market-based organizations had placed on the revenue cycle.

The majority of investments limited as to use were included in the Catholic Health Initiatives operating investment program. The program had an investment return of 1.1 percent in fiscal year 2001, which compared favorably to the benchmark returns of negative 3 percent. The annualized return for the program since its inception in 1997 was 7.9 percent. The weak fiscal year 2001 returns were due to a sharp correction in equity markets.

Property and equipment declined due to sponsorship transfers and continued capital spending constraints. Capitalized asset additions were $227 million in fiscal year 2001, down from $315 million in fiscal year 2000. Long-term debt decreased by $191 million, a result of $116 million in bond redemption, mainly for the sponsorship transfers, and $82 million of ordinary debt repayments. The debt-to-capitalization ratio improved to 33.5 percent, compared to 36.7 percent at the prior year-end. The cash-to-debt ratio was 122 percent compared to 91 percent for the prior year.

Accounts payable and other current liabilities were 3 percent lower than at the prior year-end, which was also a result of sponsorship transfers. Self-insured reserves and other liabilities increased 12 percent due to favorable paid loss experience in the First Initiatives Insurance, Ltd. insurance programs.

STATEMENT OF OPERATIONS
As noted earlier, the fiscal year 2001 consolidated excess margin was 2.9 percent and, before restructuring and impairment expenses, the margin was 3.9 percent. Both compared favorably with prior-year margins of 1.7 percent and 3.4 percent, respectively.

Revenues from patient services were 6.7 percent above the prior fiscal year, a result of utilization and price increases. Inpatient admissions increased 1.3 percent and outpatient and emergency visits increased 3.8 percent. An expected negative impact on revenues due to the Medicare outpatient prospective payment system implemented on August 1, 2000 did not materialize.

Investment income of $91 million in fiscal year 2001, which was nearly half that of the prior fiscal year, was indicative of weak performance in equity markets. The decline in revenues from non-patient sources was almost entirely a result of a market-based organization’s sale of its managed care
company; because the decision to discontinue operations was made in fiscal year 2000, all estimated revenues and expenses through the projected disposition date were included as net charges in fiscal year 2000.

Expenses before restructuring and impairment charges increased by 2.9 percent compared to the previous fiscal year. The largest unfavorable variance was a 5.6 percent increase in employee compensation and benefits, which exceeded growth in utilization of services. Labor shortages placed undue pressure on the health care industry, and market-based organizations continued to seek innovative ways to manage the delivery of services in light of staffing concerns.

Supplies and other expenses increased slightly during fiscal year 2001. As a percentage of supply-related revenues, supply costs decreased to 17.1 percent from 17.4 percent in the prior fiscal year. Special attention was directed to the management of pharmaceutical usage and costs. It was a concern, however, that supply costs per case-mix-adjusted admission increased 0.7 percent between fiscal years.

Building and equipment depreciation expenses decreased 1.8 percent in fiscal year 2001. This decrease was related to both the reduction in capital spending and the sale in fiscal year 2000 of the former Lancaster, Pa., market-based organization. Patient care debts decreased 3.8 percent, a significant improvement following a 41 percent year-to-year increase in fiscal year 2000.

Management of the revenue and cash cycles also improved significantly at market-based organizations.

Interest on long-term debt increased 6.5 percent in fiscal year 2001. A bond issue occurred at the end of fiscal year 2000, resulting in higher fiscal year 2001 average debt balances. Thus, interest charges were incurred on larger balances than in the prior year. Restructuring and impairment charges, which included $48 million in losses on sponsorship transfers, were less than the prior fiscal year. Many of the prior-year charges related to the impairment of assets, principally due to discontinued operations and closures in Albuquerque, N.M., Cincinnati, Ohio, Little Rock, Ark., and at Centura Health in Colorado.

CONCLUSION

Fiscal year 2001 was a year of significant improvement for Catholic Health Initiatives, measured by financial position and financial performance. Financial results were well ahead of budgeted expectations and prior-year results. Margins still trailed the level of medical inflation, however, and the organization's challenge is to achieve further improvements in performance from operations.

Catholic Health Initiatives does not anticipate significant changes, either in markets or in federal reimbursement regulations, in the near term. This period of stabilization is expected to require less dependence on external forces to achieve improved financial results, permitting a higher level of self-direction for market-based organization.

The largest unknown operational factor in attaining improvements in financial results remained labor market shortages, especially for nursing and highly skilled professional staff.
## BALANCE SHEET
*(dollars in thousands)*

<table>
<thead>
<tr>
<th></th>
<th>2001</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current assets, including cash and accounts receivable</td>
<td>$1,283,726</td>
<td>$1,410,039</td>
</tr>
<tr>
<td>Investments limited as to use</td>
<td>$2,482,239</td>
<td>$2,140,540</td>
</tr>
<tr>
<td>Property and equipment</td>
<td>$2,283,126</td>
<td>$2,529,426</td>
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<tr>
<td>Other</td>
<td>$310,410</td>
<td>$326,998</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td><strong>$6,359,501</strong></td>
<td><strong>$6,407,003</strong></td>
</tr>
<tr>
<td>Accounts payable and other current liabilities</td>
<td>$839,420</td>
<td>$365,565</td>
</tr>
<tr>
<td>Self-insured reserves and other liabilities</td>
<td>$346,036</td>
<td>$308,053</td>
</tr>
<tr>
<td>Long-term debt</td>
<td>$1,730,894</td>
<td>$1,921,694</td>
</tr>
<tr>
<td>Net assets:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unrestricted</td>
<td>$3,333,484</td>
<td>$3,205,506</td>
</tr>
<tr>
<td>Restricted</td>
<td>$109,667</td>
<td>$106,185</td>
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<tr>
<td><strong>Total Liabilities and Net Assets</strong></td>
<td><strong>$6,359,501</strong></td>
<td><strong>$6,407,003</strong></td>
</tr>
</tbody>
</table>

## STATEMENT OF OPERATIONS
*(dollars in thousands)*

<table>
<thead>
<tr>
<th></th>
<th>2001</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenues from patient services</td>
<td>$5,354,672</td>
<td>$5,016,215</td>
</tr>
<tr>
<td>Investment income</td>
<td>$91,148</td>
<td>$179,423</td>
</tr>
<tr>
<td>Revenues from non-patient sources</td>
<td>$296,137</td>
<td>$355,799</td>
</tr>
<tr>
<td><strong>Total Revenues</strong></td>
<td><strong>$5,741,957</strong></td>
<td><strong>$5,551,437</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee compensation and benefits</td>
<td>$2,839,782</td>
<td>$2,688,111</td>
</tr>
<tr>
<td>Supplies and other</td>
<td>$1,970,961</td>
<td>$1,956,957</td>
</tr>
<tr>
<td>Building and equipment depreciation</td>
<td>$320,495</td>
<td>$326,517</td>
</tr>
<tr>
<td>Patient bad debts</td>
<td>$284,756</td>
<td>$295,884</td>
</tr>
<tr>
<td>Interest on long-term debt</td>
<td>$100,205</td>
<td>$94,122</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td><strong>$5,516,199</strong></td>
<td><strong>$5,361,591</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income Before Restructuring and Impairment Charges</td>
<td>$225,758</td>
<td>$189,846</td>
</tr>
<tr>
<td>Restructuring and impairment charges</td>
<td>$58,549</td>
<td>$93,327</td>
</tr>
<tr>
<td><strong>Excess of Revenues Over Expenses</strong></td>
<td><strong>$167,209</strong></td>
<td><strong>$96,519</strong></td>
</tr>
</tbody>
</table>
## Community Benefit Provided to The Poor and The Broader Community

*(dollars in thousands)*

<table>
<thead>
<tr>
<th></th>
<th>Year Ended June 30</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2001</td>
</tr>
<tr>
<td></td>
<td>2000</td>
</tr>
<tr>
<td>Traditional charity care costs</td>
<td>$91,655</td>
</tr>
<tr>
<td>Unpaid costs of Medicaid and other indigent care programs</td>
<td>$94,498</td>
</tr>
<tr>
<td>Non-billed services for the poor</td>
<td>$7,756</td>
</tr>
<tr>
<td>Cash and in-kind donations</td>
<td>$4,320</td>
</tr>
<tr>
<td>Other community benefit for the poor</td>
<td>$4,682</td>
</tr>
<tr>
<td><strong>Quantifiable Community Benefit for the Poor</strong></td>
<td><strong>$202,911</strong></td>
</tr>
<tr>
<td>Unpaid costs of Medicare and other senior programs</td>
<td>$348,851</td>
</tr>
<tr>
<td>Non-billed services for the broader community</td>
<td>$23,785</td>
</tr>
<tr>
<td>Education and research</td>
<td>$24,641</td>
</tr>
<tr>
<td>Other community benefit for the broader community</td>
<td>$32,342</td>
</tr>
<tr>
<td><strong>Quantifiable Community Benefit for the Broader Community</strong></td>
<td><strong>$429,619</strong></td>
</tr>
<tr>
<td><strong>Total Quantifiable Community Benefit Provided to the Poor and the Broader Community</strong></td>
<td><strong>$632,530</strong></td>
</tr>
<tr>
<td></td>
<td><strong>$548,924</strong></td>
</tr>
</tbody>
</table>

*(Total quantifiable community benefit provided to the poor and the broader community was 11 percent and 9.9 percent of total revenues for the fiscal years ended June 30, 2001 and 2000, respectively.)*

## Statistical Highlights

*(dollars in thousands)*

<table>
<thead>
<tr>
<th></th>
<th>Year Ended June 30</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2001</td>
</tr>
<tr>
<td></td>
<td>2000</td>
</tr>
<tr>
<td>Acute inpatient days</td>
<td>2,141,126</td>
</tr>
<tr>
<td>Acute care admissions</td>
<td>455,717</td>
</tr>
<tr>
<td>Average acute care length of stay in days</td>
<td>4.7</td>
</tr>
<tr>
<td>Long-term care days</td>
<td>1,240,126</td>
</tr>
<tr>
<td>Acute inpatient revenues as a percentage of revenues from patient services</td>
<td>51.4</td>
</tr>
<tr>
<td>Number of full-time employee equivalents</td>
<td>56,461</td>
</tr>
</tbody>
</table>

2001 Annual Report