From the Chair of the Board of Stewardship Trustees and the President and Chief Executive Officer

During 2006, Catholic Health Initiatives marked a significant event: our tenth anniversary as a system. We seized this opportunity to reflect on our journey to date, but also to look at the road ahead. Our first decade together was blessed with innovative beginnings. At the start, there was the enormous task of forming what was then the largest Catholic health care system in the country; and, the challenge of implementing a courageous new model of sponsorship and governance. In the years following, the more than 65,000 employees of Catholic Health Initiatives have found new ways to work together to care for the sick and the well. In the process, they blended the health ministries of 12 congregations of women religious into one national health ministry that will continue to weather the storms of a harsh health care environment.

Today, our health ministry is more than stable: it is strong. In fact, we believe this strength gives us the ability to address new challenges. One challenge that has been on our minds during the past year is this: what will it take to truly transform health care delivery, as Catholic Health Initiatives is called to do in its mission statement?

We believe the best approach to this challenge is summarized in the following three themes, which have provided focus to our work during the past year:

- Building the System Together
- Investing in Leaders to Develop Leaders
- Creating the Safest Environment by Reducing Avoidable Complications

You’ll find more information about all three in the pages that follow.

Catholic Health Initiatives has begun its second decade with a great deal of excitement about future growth; sustained excellence in leadership and clinical services; research and development; and an enduring commitment to building healthy communities. We will continue our mission focus, which makes how we do our work just as important as what we accomplish. Finally, we are blessed to lead so many talented, committed individuals on the continuing journey of our health ministry.

Esther Anderson, OSF, PhD
Chair, Board of Stewardship Trustees

Kevin E. Lofton, FACHE
President and Chief Executive Officer

Journey Together

“We don’t receive wisdom; we must discover it for ourselves after a journey that no one can take for us or spare us.”

Marcel Proust, 1871–1922
Novelist and Essayist

ON THE COVER
Maria Ramirez (center) and her daughters, Martha Ramirez (left) and Laura Ramirez (right), have the support of St. Joseph Community Health as they advocate to make their neighborhood in Albuquerque, New Mexico, a better place. Maria’s outreach work to promote St. Joseph’s childhood immunization program and to generate support for a community center will help Martha’s baby daughter, Ximena Anchendo, and many other neighborhood children grow up to lead healthier lives.
Guardians of a legacy of care, architects of a new spirit of innovation: that is today’s Catholic Health Initiatives.

Catholic Health Initiatives is continuing the journeys of health ministries begun many years ago by members of its participating congregations, who always sought to meet the health care needs of their time and place. Ten years ago, when these disparate health ministries came together as Catholic Health Initiatives, their separate journeys merged onto a single path.

The way ahead is not always clear. Outside forces obscure the view; other paths branch off in different directions. To sharpen the focus on its mission and provide a sure sense of direction, Catholic Health Initiatives was guided throughout 2006 by three themes — Building the System Together, Investing in Leaders to Develop Leaders, and Creating the Safest Environment by Reducing Avoidable Complications.
Within Catholic Health Initiatives, interdependence means creating opportunities for mutual, balanced accountability; greater efficiency; and economies of scale, all contributing to the common good. The system is increasing the interdependence of its facilities and national offices through CHI Connect, a system-wide process to standardize and centralize essential business functions, including supply chain, finance, payroll and human resources. By reducing duplication and variation in these functions, as well as easing their management at the local level, CHI Connect will help Catholic Health Initiatives’ facilities direct more resources to patient care and community health improvement.

The first phases of CHI Connect have been implemented at Catholic Health Initiatives’ national offices and at Memorial Health Care System, Chattanooga, Tennessee, which serves as the pilot site for the system’s hospitals and long-term care facilities. Ruth Brinkley, president and chief executive officer of Memorial, is a champion for CHI Connect along with Carol Newton, chief financial officer, and Lisa Whaley, vice president, human resources. “Even though change almost always brings challenges, our associates are committed to the long-term success of our mission and ministry, and understand that we will not thrive if we continue doing things exactly the same way as we have always done them,” said Brinkley. “CHI Connect offers an opportunity to strengthen our mission by leveraging our size and collective knowledge. We can do far more together than any one of us can do alone.”

Catholic Health Initiatives challenges itself to achieve year-over-year improvement in all areas, including mission, clinical services, operational and financial performance.

Two of the system’s assets — its size and scope — present opportunities for improving overall performance. Catholic Health Initiatives seeks to leverage these assets by growing as an integrated, cohesive system that supports its facilities as they meet the specific health needs of their communities.
Catholic Health Initiatives facilities are migrating a variety of information technology (IT) functions to the system’s National Information Technology Center. This migration, which standardizes and eliminates duplication, fuels Catholic Health Initiatives’ growth as an integrated system. It also provides local facilities with system-level expertise and support for their IT functions.

Local facilities are also migrating patient financial services to Catholic Health Initiatives’ Central Business Offices in Exton, Pennsylvania, and Nampa, Idaho. The Central Business Offices manage patient accounts, giving local patient services staff more time to focus on personalized service and support for individual patients. Catholic Health Initiatives plans to open a third Central Business Office in 2007 in Fargo, North Dakota, to support facilities in North Dakota and Minnesota.

“After migrating patient financial services to Catholic Health Initiatives’ Central Business Office, our costs as a percentage of net patient services revenue have gone down $165,000,” said Joseph Messmer, president and chief executive officer of Mercy Medical Center, Nampa, Idaho. “We have excellent communication and accountability between our hospital and the Central Business Office. We’ve had no patient complaints about untimely billing, and days in accounts receivable are the lowest in 20 years.”
Throughout its ten-year journey, Catholic Health Initiatives has maintained open communications between the national organization and local boards of directors: the individuals who represent the facilities to the local community and represent the needs and preferences of their communities to the system. New board members attend orientation sessions that make them more aware of the history and structure of Catholic Health Initiatives and the many ways in which the system supports its local facilities.

The skills and commitment of local board members were essential to a joint venture recently created by CARITAS Health Services and Jewish Hospital HealthCare Services in Louisville, Kentucky. The first chair of the board of the new organization, called Jewish Hospital & St. Mary’s HealthCare, was Julian “Pinky” Shapero, a Modern Healthcare Trustee of the Year for 2006. “Jewish Hospital & St. Mary’s HealthCare is an excellent, complementary fit of faith-based health providers,” he said. “JHHS brought local market strength and clinical programs that are nationally ranked for excellence; CARITAS brought that same commitment to excellence, local expertise and the strength of Catholic Health Initiatives as a national health care system. The cultures were similar in many ways, and the respect that JHHS and CARITAS showed to each other was outstanding. Things have worked out even better than we thought.”

During its first ten years, Catholic Health Initiatives’ Mission and Ministry Fund achieved two remarkable accomplishments. While awarding approximately $21 million in grants to build healthy communities, the fund also reached its goal of $100 million in principal. The principal accumulated through annual contributions from Catholic Health Initiatives’ facilities will now continue to grow — and to fund new grants — through earnings on investments.

The $21 million in grants helped create and strengthen many healthy community coalitions, as well as programs that address specific health needs. One of these is Brush. Brush. Smile!, created by St. Joseph Health Ministries to meet the oral health needs of children in Lancaster County, Pennsylvania. In addition to classroom-based oral health education, the program provides direct treatment via the colorful Brush Brush Bus. This converted, 40-foot motor coach houses a complete mobile dental clinic that visits schools throughout Lancaster County.
In 2003, A Supportive Journey Toward Dying, a program led by Saint Francis Medical Center, Grand Island, Nebraska, received a grant of $140,856 from the Mission and Ministry Fund. In 2006, the Mission and Ministry Fund presented Saint Francis with the first John Andrew Hackley Memorial Award, which recognizes extraordinary work in the area of palliative care. A Supportive Journey Toward Dying brings together a coalition of more than 30 community organizations to change negative attitudes about dying and to support individuals who are in the last stages of life, as well as the loved ones who survive them. Diane Panowicz and her colleagues supported this Grand Island woman and her husband as he was dying, particularly by helping the couple to communicate with physicians about treatment options.

On May 15, 2006, employees throughout Catholic Health Initiatives gathered to celebrate the tenth anniversary of the organization through coordinated prayer services. With candle lightings, readings, prayer and song, they honored those who created Catholic Health Initiatives; those who contributed to its first ten years; and all who continue to advance the health ministry today.

The St. Anthony Hospital Singers (top) sang “City of God” at St. Anthony Hospital, Pendleton, Oregon. SharRay Feickert (center), president and chief executive officer, participated in the candle ritual during the tenth anniversary prayer service at Lakewood Health Center, Baudette, Minnesota. The prayer service at Flaget Memorial Hospital in Bardstown, Kentucky (bottom), took place in the hospital’s chapel. Frances Krumpelman, SCN, a member of the board, took part in the readings.

To help preserve its history, Catholic Health Initiatives published a book detailing the events that led to its formation, the creation of its mission and the challenges and accomplishments of its first seven years. Catholic Health Initiatives: The Early Years was written by Maryanna Coyle, SC, a member of the Steering Council that created Catholic Health Initiatives and the first chair of the Catholic Health Initiatives Board of Stewardship Trustees; and Patricia A. Cahill, Esq., the first president and chief executive officer. It is a definitive reference to the personalities and events that contributed to the founding of Catholic Health Initiatives.
Catholic Health Initiatives is committed to becoming a work community of choice in every market it serves. This concept was introduced soon after the formation of the system through a document called Catholic Health Initiatives Work Community Guidelines, which stated: “Together, as a values-driven work community, we can fulfill our mission to bring new life, energy and viability to our health care ministry, today and into the future.” Leaders in Catholic Health Initiatives’ national offices and local facilities take responsibility for creating work environments that are desirable to employees as well as patients, residents and the community. Achieving such a work environment requires flexibility and sensitivity to meet the practical, everyday needs of employees while supporting their dreams for the future.

More than ten years ago, the foundresses of Catholic Health Initiatives pondered the future of leadership for their carefully nurtured health ministries. They had faith that lay leaders would be able to match the sisters’ commitment to the preservation and advancement of the Catholic health ministry. Within Catholic Health Initiatives today, all leaders are entrusted with responsibility for guiding the system on its continuing journey. Part of this responsibility is the development of current and future leaders whose behaviors and actions are rooted in the system’s core values: Reverence, Integrity, Compassion and Excellence.

Saint Elizabeth Health Systems, Lincoln, Nebraska, creates a work community of choice by making leadership an inclusive concept. “At Saint Elizabeth, everyone is a leader,” said Robert Lanik, president and chief executive officer. “Our classes in leadership skills, and our spiritual retreats for personal development, are open to everyone in the organization. For us, this broad and inclusive approach creates a great culture and work environment.”
Preventive medicine and fitness are important components of the work environment at Mercy Medical Center-Des Moines, Iowa, where employees are invited to an annual “Walk with Dave.” Walking with Dave Vellinga, president and chief executive officer of the medical center and chair of Mercy Health Network, also gives employees the opportunity to talk informally with him.

From left, Pat Cavanaugh, Dave Vellinga, Josh Stople, Jacquie Easley and Carrie Gutwin, Mercy Medical Center-Des Moines, Iowa
Investing in Leaders to Develop Leaders:
National Leadership Conference

When leaders from across Catholic Health Initiatives gathered in Denver for the organization’s 2006 National Leadership Conference, the event marked the beginning of the system’s second decade. The conference theme, “Reaching New Heights as One,” reflected the system’s continuing journey as an interdependent organization, fulfilling the vision of the foundresses.

To tell the story of Catholic Health Initiatives in a visual manner, the system created a story wall, now housed in the system’s Denver office, which uses images to illustrate the journey of the first ten years.

The Catholic Health Initiatives Chorale

Patricia A. Cahill, Esq.

Rosemary Gibson and Maryanna Coyle, SC

Kevin Lofton

Esther Anderson, OSF, PhD

To tell the story of Catholic Health Initiatives in a visual manner, the system created a story wall, now housed in the system’s Denver office, which uses images to illustrate the journey of the first ten years.
Being an effective leader sometimes means stepping off the path of leadership for an enlightening side trip through another area of life. The Board of Stewardship Trustees of Catholic Health Initiatives created the Patricia A. Cahill Leadership Initiative in 2003 to offer leaders the opportunity to take time away from their jobs to pursue education, research, writing, community service or some combination of these endeavors. The initiative is named in honor of Patricia A. Cahill, Esq., the first president and chief executive officer of Catholic Health Initiatives and a firm believer in leadership development.

Allen Montgomery, Esq., vice president and senior legal counsel for Catholic Health Initiatives, received one of the first Cahill grants. His multifaceted sabbatical took him to Oxford University in England as a visiting scholar; to the Baptist World Congress in Birmingham, England; and to Gdansk, Poland, where he helped construct a Habitat for Humanity house for a working-class family.

“The Patricia Cahill Leadership grant provided a rare opportunity to learn for the sake of learning and personal growth,” he said. “Being able to study at Oxford and volunteer with Habitat for Humanity were life-changing experiences that challenged me and helped me to grow, both professionally and personally. I am extremely grateful for the opportunity Catholic Health Initiatives provides through the Cahill Leadership grants — an opportunity I think is quite unique among large employers.”

Catholic Health Initiatives’ Executive Diversity Fellowship Program draws potential leaders from diverse backgrounds into the health ministry. The program is designed to attract high-potential managers from minority groups, including women and ethnic minorities, to prepare for executive leadership roles within Catholic Health Initiatives. Raleigh Heard started his executive diversity fellowship in January 2006. His mentors include Michael Rowan, executive vice president and chief operating officer, Gary Campbell, senior vice president of operations, and John Tolmie, president and chief executive officer, St. Joseph Medical Center, Towson, Maryland. “I consider it an honor to join an organization with such a rich tradition of excellence and compassion, and to have the breadth and depth of hands-on experience provided by this fellowship,” said Heard.
Creating the Safest Environment by Reducing Avoidable Complications

In its continuing journey toward the transformation of health care delivery, Catholic Health Initiatives is committed to creating the safest health care environment by reducing avoidable complications, with high-quality care as a natural result.

The system’s achievements in patient care and safety during 2006 are a testament to the effectiveness of its focus on person-centered care, competent staffing and evidence-based practices.

Catholic Health Initiatives’ health care facilities use evidence-based practices to reduce avoidable complications, including the seven interventions known to reduce mortality and promoted by the Institute for Healthcare Improvement in its 100,000 Lives Campaign, a national effort to save 100,000 lives from December 2004 to June 2006. Through implementation of these and other clinical initiatives, Catholic Health Initiatives reduced its system-wide mortality rate by more than six percent, equal to 450 lives, during the 2006 fiscal year.

Saint Joseph HealthCare, Lexington, Kentucky, was a pioneer in reducing the incidence of ventilator-associated pneumonia (VAP) by elevating the heads of ventilated patients 30 degrees. The Institute for Healthcare Improvement recognized Saint Joseph’s excellent and early work with this intervention, which became part of the organization’s bundle of recommendations for preventing VAP.

Jeanette Callaway, RN, and Roger Norfleet, respiratory therapist, with a patient at Saint Joseph HealthCare, Lexington, Kentucky
Catholic Health Initiatives continues to implement its Advanced Clinical Information Systems (ACIS) initiative, which is working toward system-wide use of automated patient records, clinician order entry, medication administration and other clinical tools. The benefits will include increased accuracy in clinical tasks ranging from transcription to specimen tracking, as well as improved access to vital patient information — all leading to improvement in the quality of patient care.

Saint Joseph HealthCare, Lexington, Kentucky, is one of five Catholic Health Initiatives organizations that implemented several ACIS modules during the past year, including PACS (Picture Archival and Communication System). Saint Joseph’s PACS provides digital integration of all three of the organization’s hospitals: images for a patient admitted at one hospital can be viewed at any of the three, assisting in diagnoses and patient transfers. While PACS images can be viewed from any computer that has Internet access, Saint Joseph’s radiologists use the high-resolution monitors shown here for diagnostic purposes. PACS implementations throughout Catholic Health Initiatives have resulted in a 95 percent use of filmless technology, saving an estimated $4 million.
At Saint Francis Medical Center, Grand Island, Nebraska, rapid response team members arrive quickly when called to evaluate a patient. With its rapid response team program in place since May 2005, Saint Francis was an early adopter among rural hospitals. The medical center attributes an eight percent decrease in codes to its rapid response teams. Saint Francis has also been selected as a mentor hospital for rapid response teams by the Institute for Healthcare Improvement.

Across Catholic Health Initiatives, the implementation of rapid response teams during 2006 helped reduce the system’s mortality rate by more than six percent. Rapid response teams are made up of clinicians — physicians, nurses, respiratory therapists and others — who are called when a patient shows signs of rapid decline. “Rapid response teams make sense in theory,” said Richard Boehler, MD, chief medical officer and champion of the rapid response team program at St. Joseph Medical Center, Towson, Maryland. “But, when you actually watch a team save a patient’s life and experience the gratitude of the family and the primary caregivers — that’s when you truly see what an excellent tool they are. This has been one of the highlights of my professional career.”
Core Strategy: People

Catholic Health Initiatives will create the work community of choice — built upon common values — in every market it serves.

Sacred Stories
Catholic Health Initiatives published the seventh volume in its book series, Sacred Stories. These volumes are collections of stories, written by employees and others associated with Catholic Health Initiatives, which document memorable moments of lived spirituality at work.

Leadership Formation
An important element of Catholic Health Initiatives’ leadership development program, a course titled “Leadership That Shapes the Future,” provides a solid foundation for understanding and advancing the Catholic health ministry and incorporating spirituality into inspiring leadership. By the end of the 2006 fiscal year, more than 500 Catholic Health Initiatives leaders had completed this development course.

Leadership Continuity
To help ensure strong leadership for the future of its health ministry, Catholic Health Initiatives conducted leadership continuity planning for its national leadership team and facility-based chief executive officers.

Patricia A. Cahill Leadership Initiative
The Patricia A. Cahill Leadership Initiative — created to allow Catholic Health Initiatives leaders time away from their jobs to pursue education, research, writing or community service — awarded a grant to Carl Middleton, DMin, vice president of theology and ethics.

Core Strategy: Quality

Catholic Health Initiatives will be recognized as a national leader in person-centered care.

Sharpened Focus
In keeping with its tradition of care for the body, mind and spirit, Catholic Health Initiatives sharpened its focus on person-centered care, which emphasizes involving patients and their loved ones in care decisions and giving them control over care received.

Rapid Response Teams
The Robert Wood Johnson Foundation awarded a $145,000 grant to Catholic Health Initiatives to assist in the implementation of rapid response teams throughout the system. Rapid response teams, one intervention recommended by the Institute for Healthcare Improvement’s 100,000 Lives Campaign, are comprised of patient care providers who are called to respond to the bedside when a patient’s condition deteriorates rapidly.

Mortality Reduction
Through the implementation of rapid response teams, strategic staffing and evidence-based practices, Catholic Health Initiatives’ facilities reduced mortality 6.25 percent during fiscal year 2006, the equivalent of 450 lives saved.

Data From Source
Catholic Health Initiatives enhanced its Data From Source project, which gathers and analyzes clinical data from throughout the system, with an interactive analysis tool. Catholic Health Initiatives leaders use the tool to search for data and view reports related to specific types of clinical cases, which promotes the sharing of best practices.

White House Conference on Aging
Roger DeMark, president and chief executive officer of Franciscan Villa, South Milwaukee, Wisconsin, represented Catholic Health Initiatives as a delegate to the White House Conference on Aging, a forum for the discussion and development of recommendations to help guide national programs and policies that affect the elderly.

Culture of Safety Survey
All of Catholic Health Initiatives’ facilities completed a Culture of Safety Survey from the Agency for Healthcare Research and Quality (AHRQ), establishing baseline measures of safety for individual facilities and the system as a whole. AHRQ recognized Catholic Health Initiatives as a best-practice organization in the management of the survey process.
Core Strategy: Stewardship

Catholic Health Initiatives will steward resources to innovate and excel in meeting the needs of the communities it serves.

Change Leadership
To help leaders and employees implement timely, effective change, Catholic Health Initiatives introduced a change leadership initiative, based on tools and processes originally developed by GE Healthcare. During 2006, Catholic Health Initiatives trained more than 130 employees to lead a process of change acceleration and management that is custom-designed for the organization.

Annual Planning Reviews
As Catholic Health Initiatives’ information technology team implemented 63 major new clinical and business tools across the system — more than one a week — to support its facilities, Catholic Health Initiatives also created a comprehensive Information Management Plan to prioritize information management and technology initiatives throughout the system.

Lofton to Serve as Chair of American Hospital Association
Kevin Lofton, president and chief executive officer of Catholic Health Initiatives, became chair-elect of the American Hospital Association (AHA) on January 1, 2006. He will serve as chair for a one-year term beginning January 1, 2007. Lofton was also 16th on the 2006 list of the 100 Most Powerful People in Healthcare published by Modern Healthcare magazine. In September 2006, Lofton represented the AHA to testify on nonprofit hospitals charitable care and community benefit before the U.S. Senate Finance Committee.

Strategic and Financial Planning Calendar
Catholic Health Initiatives developed a new Strategic and Financial Planning Calendar to integrate and coordinate the multiple planning and financial cycles of its facilities, national staff and Board of Stewardship Trustees.

Information Technology
Catholic Health Initiatives’ information technology team implemented 63 major new clinical and business tools across the system — more than one a week — to support its facilities. Catholic Health Initiatives also created a comprehensive Information Management Plan to prioritize information management and technology initiatives throughout the system.

Core Strategy: Growth
Catholic Health Initiatives will extend the scope and influence of the Catholic health ministry.

Jewish Hospital and St. Mary’s HealthCare
CARITAS Health Services and Jewish Healthcare Services, Louisville, Kentucky, formed a joint venture named Jewish Hospital & St. Mary’s HealthCare. Along with the merger, the former CARITAS Board of Directors approved name changes for CARITAS facilities: CARITAS Medical Center was renamed Sts. Mary & Elizabeth Hospital, and CARITAS Peace Center was renamed Our Lady of Peace.

Mission and Ministry Fund
The Mission and Ministry Fund of Catholic Health Initiatives awarded 16 grants, totaling nearly $2 million, for the building of healthy communities. In its ten-year history, the Fund has awarded a total of approximately $21 million through 175 grants.

Global Health Initiatives
Global Health Initiatives, created to expand the international mission work of Catholic Health Initiatives and its facilities, helped create a sister-to-sister relationship between St. Anthony Central Hospital, Denver, Colorado, and Bach Mai Hospital, Hanoi, Vietnam. Several Catholic Health Initiatives organizations have also sponsored the following collaborative international mission projects:
- Accra, Ghana — Mercy Medical Center, Nampa, Idaho
- Comboni Clinic, Guatemala – TriHealth, Cincinnati, Ohio
- Gonazex, Haiti – St. Mary-Corwin Medical Center, Pueblo, Colorado
- Karatu District, Tanzania – Mercy Medical Center, Durango, Colorado, and St. Joseph Medical Center, Towson, Maryland
- Orlu, Nigeria – Mercy Medical Center, Roseburg, Oregon
- Saint Luca, West Indies – Holy Rosary Medical Center, Ontario, Oregon

Healthy Community Forum
Catholic Health Initiatives hosted a Healthy Community Forum in March, immediately following the Association for Community Health Improvement’s national conference. Leaders of healthy community coalitions supported by Catholic Health Initiatives’ facilities shared their challenges and solutions.
Honors for Catholic Health Initiatives Facilities

The following Catholic Health Initiatives facilities and joint operating companies received recognition during the 2006 fiscal year.

**American Heart Association “Get With the Guidelines” Coronary Artery Disease Annual Performance Achievement Award**
- St. Anthony Central Hospital, Denver, Colorado

**American Hospital Association NOVA Award**
- (The NOVA Award recognizes hospitals and health systems for collaborative efforts toward improving community health)
- Saint Joseph HealthCare, Lexington, Kentucky

**American Society for Bariatric Surgery**
- Saint Joseph Medical Center, Towson, Maryland

**HealthGrades Distinguished Hospital Award for Patient Safety**
- Memorial Health Care System, Chattanooga, Tennessee
- St. Joseph Medical Center, Towson, Maryland

**HealthGrades Specialty Excellence Award**
- Alegent Health, Omaha, Nebraska (Gastrointestinal Services)
- Good Samaritan Hospital, Cincinnati, Ohio (Pulmonary Services)
- Good Samaritan Hospital, Dayton, Ohio (Vascular Services)
- Marymount Medical Center, London, Kentucky (Pulmonary Services)

**HealthGrades Distinguished Hospital Award for Clinical Excellence**
- Memorial Health Care System, Chattanooga, Tennessee (Cardiac, Critical Care and Vascular Services)
- Mercy Medical Center, Roseburg, Oregon (Pulmonary Services)
- Mercy Medical Center-Des Moines, Iowa (Pulmonary Services)
- Penrose-St. Francis Health Services, Colorado Springs, Colorado (Critical Care and Pulmonary Services)
- St. Anthony Central Hospital, Denver, Colorado (Stroke Services)
- St. Joseph Medical Center, Tacoma, Washington (Orthopedic Services)

**Jackson Organization Awards: Overall Employee Satisfaction and Engagement**
- Small (less than 755 employees)
  - First Place — Our Lady of the Way Hospital, Martin, Kentucky
  - Second Place — Gaffney Medical Center, South Carolina
- Medium (750 to 1,500 employees)
  - First Place — Mercy Medical Center, Rockford, Oregon
  - Second Place — Saint Vincent Health System, Little Rock, Arkansas

**Jackson Organization Awards: Consumer (highest brand equity score in the primary service area)**
- Most Improved — Saint Joseph Benet, Benet, Kentucky

**Jackson Organization Awards: Overall Emergency Department Satisfaction**
- Most Improved — Our Lady of the Way Hospital, Martin, Kentucky
- Small (less than 100 beds)
  - First Place — Summit Medical Center, Gettysburg, South Dakota
- Medium (100 to 249 beds)
  - First Place — Mercy Medical Center, Rockford, Oregon
  - Second Place — Saint Vincent Health System, Little Rock, Arkansas

**Jackson Organization Awards: Outpatient**
- Small (less than 100 beds)
  - First Place — Our Lady of the Way Hospital, Martin, Kentucky

**Jackson Organization Awards: Inpatient Satisfaction**
- Small (less than 100 beds)
  - First Place — St. Gabriel’s Hospital, Little Falls, Minnesota
  - Second Place — Mercy Medical Center, Williston, North Dakota
- Medium (100 to 249 beds)
  - Second Place — Saint Francis Medical Center, Grand Island, Nebraska
  - Large (250 or more beds)
    - First Place — Memorial Hospital, Chattanooga, Tennessee

**Jackson Organization Awards: Unit-Specific Awards**
- Impatient — Maternity
  - Mercy Medical Center, Williston, North Dakota
  - Saint Francis Medical Center, Grand Island, Nebraska
- Impatient — Medical/Surgical
  - Saint Francis Medical Center, Grand Island, Nebraska
  - Saint Joseph Hospital, Lexington, Kentucky
- Impatient — Cardiovascular
  - Memorial Hospital, Chattanooga, Tennessee
  - Telemetry Memorial Hospital, Chattanooga, Tennessee
- Impatient — Oncology
  - Saint Joseph Hospital, Lexington, Kentucky
  - Radiation Oncology
  - Saint Joseph Hospital, Lexington, Kentucky
  - Outpatient — Same Day Surgery
  - St. Anthony’s Medical Center, Milwaukee, Wisconsin

**Solucient 100 Top Hospitals®**
- Performance Improvement Leaders
  - Penrose-St. Francis Health Services, Colorado Springs, Colorado
  - Saint Joseph East, Lexington, Kentucky
  - Saint Vincent Infirmary Medical Center, Little Rock, Arkansas

**National Research Corporation Consumer Choice Award for Quality and Image**
- Memorial Hospital, Chattanooga, Tennessee
  - Mercy Medical Center-Des Moines, Iowa
  - Penrose-St. Francis Health Services, Colorado Springs, Colorado
  - St. Joseph Medical Center, Tacoma, Washington

**U.S. News & World Report America’s Best Hospitals**
- Mercy Medical Center-Des Moines, Iowa
  - Penrose-St. Francis Health Services, Colorado Springs, Colorado

**Cardiovascular Benchmarks for Success**
- Summit Medical Center, Gettysburg, South Dakota
  - St. Anthony Central Hospital, Denver, Colorado
  - St. Anthony Medical Center, Louisville, Kentucky (Gastrointestinal, Pulmonary and Stroke Services)
Board of Stewardship Trustees

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- Martha Walsh, SC, RN
- Daniel J. Harrington, CPA
- Blackford Middelton, MD
- Patricia Smith, OSF, JCD
- Mary Jo Potter

Seated (left to right):

- Phyllis Hughes, RSM, DPFH
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Seated (left to right):

- Elizabeth Wendeln, SCN, Chair
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- Blackford Middelton, MD
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- Mary Jo Potter
- Gemma Deo, OIP

Not pictured:

- Gemma Doll, OP
- Rebecca Metzer, OSF
- Francis Schumacher, OSB
- Celine Warnilo, CSFN
- Eleanor F. Martin, SCN, Esq.
- Alice Amato, OIP
Catholic Health Initiatives completed the fiscal year ended June 30, 2006, with a sound financial position. Evidence of balance sheet strength was particularly significant, with 207 days of total cash and favorable liquidity indicators.

The financial results of operations showed modest year-over-year financial improvement, an encouraging outcome given that utilization levels were virtually flat between years. The excess margin before investment income was 3.9 percent, up from 3.7 percent in 2005. The operating EBIDA (earnings before interest, depreciation and amortization) margin before investment income was 10 percent, up from 9.8 percent in 2005. The excess of revenues over expenses margin was 9.1 percent and the EBIDA margin was 14.9 percent for fiscal 2006, compared to 7 percent and 12.9 percent for fiscal 2005, respectively.

A major structural change occurred in 2006, which had an impact on financial comparisons between years. The former Louisville, Kentucky, market-based organization was combined into a joint venture, in which Catholic Health Initiatives established a 25 percent interest with Jewish Hospital Healthcare Services. Thus, beginning in November 2005, the Louisville results were excluded from the consolidated financial statements. Only changes caused by operating results of the venture are now included in the financial statements under the equity method of accounting.

Financial Accounting Standards Board Interpretation No. 47, Accounting for Conditional Asset Retirement Obligations, was adopted in 2006. As a result, $30 million of estimated obligations were recorded to remediate environmental issues such as asbestos. While the pronouncement did not impact the statement of operations for this first-time entry, any future liability adjustments will be recorded in the statement of operations.
Utilization of Services

As mentioned, utilization was relatively flat in 2006 compared to the prior year. Inpatient admissions declined less than 1 percent, excluding the impact of the prior-year sale of the Louisville Joint Venture. The average length of stay (4.4 days) and overall case-mix index (1.13) were consistent with the prior year, reflective of a relatively high proportion of rural providers.

Outpatient visits decreased 1 percent from the prior year, excluding the Louisville impact, with emergency visits up a little more than 1 percent but non-emergency visits down nearly 2 percent. In some markets, patients have been utilizing hospital emergency services instead of typical primary care. Excluding Portland, home-based visits increased 10 percent. While some of the variance was related to changes in counting methodologies, there was a 6 percent increase in full-time equivalent physicians and extenders.

Long-term care days declined 5 percent, adjusted for Louisville. The decrease was primarily due to the prior-year sale of the market-based organization in Portland, Oregon, and closure of long-term care units at two other locations. The number of home-based patients served also was affected by a change in counting methodology. Excluding the change, home-based patients grew 1 percent. Residential days of service decreased 5 percent, entirely due to the prior-year sale of the Portland facility. Excluding Portland, residential days increased 1 percent.

Total assets increased 8 percent to $9.6 billion at June 30, 2006. Without Louisville, the year-over-year growth was 9 percent. Balance sheet financial position is a major strength for Catholic Health Initiatives, as evidenced by the continued “AA” ratings through the Moody’s, Standard and Poor’s and Fitch debt rating agencies. The 207 days of total cash was the highest year-end level ever reported by Catholic Health Initiatives, surpassing the previous high of 206 days in 2005.

Investments and assets limited as to use, which increased 4 percent to $3.8 billion, included $2.8 billion of funds internally designated for capital and other needs. Investment income contributed heavily to the growth and the increased number of days of total cash. Market-based organization contributions to the Mission and Ministry Fund ceased in 2006 in accordance with board policy and the fund reached $108 million at June 30, 2006. Grants of $1.9 million were provided from the Mission and Ministry Fund for various programs and services, primarily to market-based organizations. The Capital Resource Pool reached a balance of $203 million at the close of fiscal 2006, with $26 million designated for funding of approved costs for CHI Connect (a system to standardize and consolidate financial, human resources, payroll and supply chain information across all markets) and $21 million for the combination of two market-based organizations at Lexington and Berea, Kentucky.

Capitalized asset additions in fiscal year 2006 totaled $780 million, an increase of 9 percent above prior-year expenditures of $718 million. As a result, net property and equipment increased 11 percent. While significant levels of capital investment are expected to continue, major facility replacement and renovation projects are expected to gradually decline in favor of significant information and clinical technology needs. Management continues to focus on implementation of three important multi-year projects to enhance information needs — the Advanced Clinical Information System, CHI Connect and digital imaging.

The increase in other assets was primarily caused by additional loans made by: the debt program to two joint operating agreement partners; the assumption of an intercompany note payable by the new Louisville joint venture; and a $42 million increase in the value of two interest rate swaps. Self-insured reserves and other liabilities decreased 20 percent, with part of the decrease driven by a positive change in the retirement plan funding status. Although underfunded in 2005, favorable investment performance in 2006, along with a change in the discount rate and increased pension contributions, allowed the accumulated benefit obligation for the retirement plan to reach fully-funded status. An increase in the First Initiatives Insurance Limited loss reserve liability offset this decrease. The First Initiatives board has previously established a multi-year goal to increase self-insured retention in light of rising professional liability and workers compensation costs. Positive loss cost experience and significantly improved investment earnings in 2006 enabled First Initiatives to modify rate increases for future years and expand coverage, retention and risk as needed.

Long-term debt decreased 5 percent, to $2.2 billion, in 2006. The debt-to-capitalization ratio declined to 27.5 percent and the cash-to-debt ratio climbed to 149 percent, both significantly positive in comparison to the prior year. Unrestricted net assets increased 19 percent to $5.7 billion, largely resulting from $694 million in excess of revenues over expenses. Restricted net assets decreased only 1 percent from the prior year.

Balance Sheet

As a result, net property and equipment increased 11 percent. While significant levels of capital investment are expected to continue, major facility replacement and renovation projects are expected to gradually decline in favor of significant information and clinical technology needs. Management continues to focus on implementation of three important multi-year projects to enhance information needs — the Advanced Clinical Information System, CHI Connect and digital imaging.

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Statement of Operations

The 2006 excess of revenues over expenses of $705 million before restructuring, impairment and other losses far exceeded any year since the formation of Catholic Health Initiatives. The investment income of $411 million was the highest ever reported, and accounted for more than half of the excess of revenues over expenses before restructuring, impairment and other losses.

The 2006 EBIDA margin before investment income improved from 2005, with 22 out of a total of 45 markets improving their margins in comparison to the prior year. Eighteen markets accounted for 85 percent of EBIDA before investment income and generated 87 percent of revenues from patient services.

Revenues from patient services increased 5.3 percent in 2006, less, at 5.6 percent, but still sufficient to cover a 5.3 percent increase in expenses. Employee compensation and benefits, coupled with supplies, represented nearly 70 percent of expenses in 2006. Employee compensation and benefits were 50 percent of expenses, a 5 percent increase over 2005 primarily due to higher labor costs. Although staffing decreased 1 percent, much of the year-to-year variance was due to the 2005 sale of the Portland market-based organization and the 2006 Louisville transfer of operations. Excluding these changes, staffing actually increased 3 percent over the prior year.

Supply expenses increased 4 percent, significantly below the 5 percent growth in revenues from patient services. As a percentage of net patient services and other revenues, supply expenses decreased slightly to 18.2 percent. However, when evaluated on the basis of admissions adjusted for case-mix index, supply expenses were 7 percent higher in 2006 than in 2005. Market-based organizations have begun to analyze supply contracting and costs as part of CHI Connect, which is expected to provide significant supply chain savings. Many markets already are realizing some of these anticipated savings.

Similar to the past several years, the growth in patient bad debts significantly outpaced the growth in revenues from patient services. Many patients have little or no insurance coverage due to decreased coverage by employers and the transfer of costs to patients through growing co-pays and deductibles. Bad debts and charity care, combined as a percentage of revenues from patient services, increased to 14 percent in 2006, com pared to 13 percent in the prior fiscal year, resulting in a negative year-to-year impact of $48 million on the excess of revenues over expenses.

Interest expenses were 6 percent above the prior year as a result of a full 12 months of interest costs in 2006, related to the November 2004 bond issue that increased net long-term debt by $310 million. The greatest component of the 7 percent increase in other expenses was an operational change in one of the joint operating agreements, raising management fees by transferring certain functions from the facilities into the joint management company. In addition, a $3 million increase in state provider taxes occurred at one market-based organization while another recognized $4 million in charges related to donation commitments.

Restructuring, impairment and other losses were $12 million in 2006, significantly below the $41 million reported in 2005. The primary components in 2006 included the impairment of medical office buildings at two market-based organizations and a write-down of intangible assets related to the acquisition of certain ancillary services at another market-based organization.

Community Benefit and Charity Care

The cost of community benefit was $467 million in fiscal year 2006, which was 5 percent greater than the prior year. Community benefit includes the cost of supplies and labor related to free clinics, donations and other programs and services provided for people who are poor and local community needs. In May 2006, the Catholic Health Association of the United States issued an updated policy document, A Guide for Planning and Reporting Community Benefit. An important change in policy is the exclusion of the unpaid costs of Medicare from the cost of community benefit, and Catholic Health Initiatives has conformed to this new focus.

Conclusion

Overall, 2006 was another year of stable financial performance. Catholic Health Initiatives achieved new records for days of total cash on hand, excess of revenues over expenses and EBIDA, all driven by an extremely strong investment market. As a result of the strong financial position, significant capital investments were made to support quality person-centered care and other needs.

Catholic Health Initiatives remains committed to its focus on revenue growth and cost management. Ongoing infrastructure investments, particularly in information systems, supply chain management and master facility improvements, will leave the ministry poised to meet the growing health needs of our communities in the years to come.

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## Financial Highlights

### Balance Sheets

<table>
<thead>
<tr>
<th>At June 30</th>
<th>2006</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash, net patient accounts receivable and other current assets</td>
<td>$1,641,142</td>
<td>$1,645,671</td>
</tr>
<tr>
<td>Investments and assets limited as to use</td>
<td>3,290,014</td>
<td>3,633,189</td>
</tr>
<tr>
<td>Property and equipment</td>
<td>3,285,001</td>
<td>2,950,269</td>
</tr>
<tr>
<td>Other</td>
<td>866,213</td>
<td>621,373</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td><strong>$9,572,370</strong></td>
<td><strong>$8,840,502</strong></td>
</tr>
</tbody>
</table>

| Accounts payable and other current liabilities | 1,202,556 | 1,152,965 |
| Self-insured reserves and other liabilities | 527,792 | 662,852 |
| Long-term debt | 1,907,301 | 2,072,196 |
| **Net assets:** | | |
| Unrestricted | 5,722,771 | 4,832,066 |
| Restricted | 149,040 | 150,484 |
| **Total Liabilities and Net Assets** | **$9,572,370** | **$8,840,502** |

### Statement of Operations

<table>
<thead>
<tr>
<th>Year ended June 30</th>
<th>2006</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenues from patient services</td>
<td>$6,826,332</td>
<td>$6,501,715</td>
</tr>
<tr>
<td>Investment income</td>
<td>410,766</td>
<td>246,701</td>
</tr>
<tr>
<td>Revenues from non-patient sources</td>
<td>419,135</td>
<td>343,032</td>
</tr>
<tr>
<td><strong>Total Revenues</strong></td>
<td><strong>$7,636,233</strong></td>
<td><strong>$7,091,448</strong></td>
</tr>
<tr>
<td>Employee compensation and benefits</td>
<td>3,438,053</td>
<td>3,276,359</td>
</tr>
<tr>
<td>Supplies</td>
<td>1,302,653</td>
<td>1,254,452</td>
</tr>
<tr>
<td>Building and equipment depreciation</td>
<td>336,711</td>
<td>338,086</td>
</tr>
<tr>
<td>Patient bad debts</td>
<td>490,219</td>
<td>429,199</td>
</tr>
<tr>
<td>Interest on long-term debt</td>
<td>86,489</td>
<td>81,511</td>
</tr>
<tr>
<td>Other expenses</td>
<td>1,257,204</td>
<td>1,172,287</td>
</tr>
<tr>
<td><strong>Expenses before restructuring, impairment and other losses</strong></td>
<td><strong>$6,930,789</strong></td>
<td><strong>$6,552,094</strong></td>
</tr>
<tr>
<td><strong>Excess of revenues over expenses, before restructuring, impairment and other losses</strong></td>
<td><strong>$705,444</strong></td>
<td><strong>$539,354</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year Ended June 30</th>
<th>2006</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of Community Benefit Provided to the Poor:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost of charity care provided</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Free or reduced-cost health services for people who cannot afford to pay)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Free or reduced-cost health services for people who cannot afford to pay</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non-billed services for the poor</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Donations of food, equipment, supplies, etc., to address the needs of people who are poor or underserved)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other benefit provided to the poor</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non-billed services for the community</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Health screenings, tests, etc., provided free or at a low cost)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Education and research provided for the community</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Cancer prevention workshops, stop-smoking programs, heart disease programs, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Other benefit provided to the community</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Cost of Community Benefit and the Unpaid Cost of Medicare</strong></td>
<td><strong>$861,400</strong></td>
<td><strong>$796,598</strong></td>
</tr>
</tbody>
</table>

### Statistical Highlights

<table>
<thead>
<tr>
<th>Year ended June 30</th>
<th>2006</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute inpatient days</strong></td>
<td>1,827,488</td>
<td>1,906,401</td>
</tr>
<tr>
<td><strong>Acute admissions</strong></td>
<td>412,269</td>
<td>423,825</td>
</tr>
<tr>
<td><strong>Acute average length of stay, in days</strong></td>
<td>4.4</td>
<td>4.6</td>
</tr>
<tr>
<td><strong>Emergency visits</strong></td>
<td>1,165,730</td>
<td>1,192,533</td>
</tr>
<tr>
<td><strong>Outpatient visits</strong></td>
<td>4,370,903</td>
<td>4,421,484</td>
</tr>
<tr>
<td><strong>Physician visits</strong></td>
<td>3,458,137</td>
<td>3,251,130</td>
</tr>
<tr>
<td><strong>Home-based health patients</strong></td>
<td>45,487</td>
<td>54,370</td>
</tr>
<tr>
<td><strong>Residential days</strong></td>
<td>625,269</td>
<td>658,964</td>
</tr>
<tr>
<td><strong>Long-term care days</strong></td>
<td>722,268</td>
<td>758,660</td>
</tr>
<tr>
<td><strong>Full-time equivalent employees</strong></td>
<td>53,331</td>
<td>54,664</td>
</tr>
<tr>
<td><strong>Employees</strong></td>
<td>65,070</td>
<td>66,460</td>
</tr>
<tr>
<td><strong>Acute inpatient revenues as a percentage of total net revenues from patient services</strong></td>
<td>52.5%</td>
<td>52.4%</td>
</tr>
</tbody>
</table>

**Certain adjustments are made to the previously reported 2005 community benefit information to conform to the 2006 presentation.**