CONTINUING DISCLOSURE ANNUAL REPORT
(Filed pursuant to Rule 15c2-12(b)(5))

PROVIDENCE ST. JOSEPH HEALTH
AND THE OBLIGATED GROUP

Name, Address and Telephone Number of Obligor:

Providence St. Joseph Health
1801 Lind Ave SW
Renton, WA 98057
Attention: Venkat Bhamidipati,
Executive Vice President and Chief Financial Officer

Title of Bonds to Which Report Relates:

See **Exhibit 5** attached hereto

Fiscal Year to Which Report Relates:

Fiscal Year ended December 31, 2018

Including Management's Discussion and Analysis and Results of Operations

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About Providence St. Joseph Health

Our organization

Providence St. Joseph Health (the "System") has been a strong and stable force for more than 160 years. As one of the largest health systems in the United States, our Mission calls us to serve the most vulnerable and poor members of our community with dignity and respect, reflecting the legacy of the Sisters of St. Joseph and the Sisters of Providence. The sisters incorporated their works of charity in 1859, creating the structure for the current network of health care services.

Our vision, Health for a Better World, is driven by a fundamental belief that health is a human right. We strive to increase access to health care and our dedicated caregivers provide quality, compassionate care to all those we serve, regardless of coverage or ability to pay. In the transforming health care landscape, our advocacy and engagement reflects our deep commitment to preserve safety net programs, such as Medicaid, and working with like-minded partners and lawmakers on policies that have a meaningful impact on the health and well-being of those we serve. We are privileged to serve in vibrant markets in the western United States with growing populations, which has led to consistent increases in service utilization in these markets. We offer a comprehensive range of industry-leading services, including an integrated care delivery system for inpatient and outpatient services, directly employed and affiliated physicians, health plans, senior care and supportive housing, financial assistance programs, and educational ministries that include a high school and university.

Our Excellence Recognized in 2018

- Ranked 9 of 250 on the Forbes list of Best Employers for New Graduates
- 21 of the System's 51 hospitals were included in U.S. News and World Report's annual rankings of Best Hospitals
- Ranked 8 of 20 on the Forbes list of Best Employers for Women

The Continuing Disclosure Annual Report (the "Annual Report") is intended solely to provide certain limited financial and operating data in accordance with undertakings of the System and the Members of the Obligated Group under Rule 15c2-12 (the "Undertaking") and does not constitute a reissuance of any Official Statement relating to the bonds described above or a supplement or amendment to such Official Statement. The Annual Report contains certain financial and operating data for the fiscal year ended December 31, 2018. The System has undertaken no responsibility to update such data since December 31, 2018, except as set forth herein. This Annual Report may be affected by actions taken or omitted or events occurring after the date hereof. The System has not undertaken to determine, or to inform any person, whether any such actions are taken or omitted or events do occur. The System disclaims any obligation to update this Annual Report or to file any reports or other information with repositories or any other person except as specifically required by the Undertaking.

The System, headquartered in Renton, Washington, is governed by a sponsorship council made up of members of its two sponsoring ministries, Providence Ministries and St. Joseph Health Ministry. The System operates hundreds of programs and services across seven states. We are a diverse family of organizations striving to create health for a better world, one community at a time, while ensuring the continued vibrancy of not-for-profit, Catholic health care in the United States. Together, we are bringing quality care and services to all, with a special emphasis on those most in need.

The Mission

As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable ®

Our Values

Compassion | Dignity | Justice | Excellence | Integrity

Our Vision

Health for a Better World

Our Promise

"Know me, care for me, ease my way."

Our Strategic Plan

Innovating new approaches to strengthen the Mission and continuously improve. Guided by the Mission and our values, we are executing a strategic plan that will accelerate our progress toward achieving our vision of Health for a Better World. This far-reaching vision includes continuing to deliver high-quality, patient-centered care; ensuring patients are digitally enabled through appropriate technology; and our ministries serve as a partner in health for the patients and communities we serve. We intend to achieve this by focusing on the core areas of revenue growth, capital efficiency and modernization. Our integrated strategic and financial plan is supported by three key principles:

Strengthen the core. We will deliver outstanding, affordable health care, housing, education and other essential services to our patients and communities by:

- Delivering safe, compassionate, high-value quality health care
- Stewarding our resources to improve operational earnings
- Fostering community commitment to our Mission via philanthropy
- Creating a work experience where caregivers are developed, fulfilled and inspired to carry on the Mission
- Being the provider of choice in all our communities

Be our communities' health partner. We will be our communities' health partner, working to achieve the physical, spiritual and emotional well-being of all. We seek to ease the way of our communities by:

- Transforming care and improving population health outcomes, especially for those who are poor and vulnerable
- Leading the way in improving our nation's mental and emotional well-being
- Extending our commitment to whole person care for people at every age and stage of life
- Engaging with partners in addressing the social determinants of health, with a focus on education, housing, and the environment
- Being the preferred health partner for our communities, and those we serve

Transform our future. We will respond to the evolving health care landscape, pursuing new opportunities that transform our services, in a strategic and effective manner. We seek to expand our share of lives and health spend and further sustain our Mission by:

- Diversifying sources of earnings to ensure sustainability of the ministry
- Digitally enabling, simplifying, and personalizing the health experience
- Creating an integrated scientific wellness, clinical research and genomics program that is nationally recognized for breakthrough advances
- Utilizing insights and value from big data to drive strategic transformation
- Activating the voice and presence of the System nationally to improve health policies

Strategic affiliations. As part of our overall strategic planning and development process, the System regularly evaluates and, if deemed beneficial, selectively pursues opportunities to affiliate with other service providers and invest in new facilities, programs, or other health care related entities. Likewise, we are frequently presented with opportunities from, and conduct discussions with, third parties regarding potential affiliations, partnerships, mergers or acquisitions, including some that could affect the Obligated Group Members. System management pursues such arrangements when there is a perceived strategic or operational benefit that is expected to enhance our ability to achieve the Mission and/or deliver on our strategic objectives. As a result, it is possible that the current organization and assets of the Obligated Group may change. At this time, all such discussions are preliminary in nature and do not necessarily indicate an intention to expand or contract the System, through partnership, affiliation, merger or acquisition, or to add or withdraw Members of the Obligated Group.

Industry Trends

The formation of new coalitions will make 2019 an inflection point in health care. We anticipate many diverse organizations will come together to collaborate on key issues. We expect to see changes that measurably improve health, affordability and transparency. We are tracking the following developments ahead:

- **Diverse coalitions** will form to address challenges in health care. In 2018, we were one of seven health systems that banded together to launch Civica Rx, a not-for-profit generic drug company formed to address the crisis of rising generic pharmaceutical costs and drug shortages. We expect more non-traditional coalitions with providers asserting stronger leadership in areas such as big data, digital innovation and advocacy.
- **Tech industry talent** will continue to join health care to help develop innovative solutions that will improve health and the delivery of care. We have been a leader in recruiting talent from outside the industry, including the recent hiring of our new chief information officer.
- **Data security** will be a primary concern as cloud computing improves how providers aggregate and leverage data to support more informed clinical decision making and enable predictive analytics. As providers build partnerships with tech firms to address these issues, providers will serve as leading advocates for ensuring patient data is secure and confidential.
- **Improving quality and reducing costs in the Medicaid program** will be a key focus. Medicaid is a critical program and vital safety net for one in five Americans. Providers will continue to be a strong voice for preserving Medicaid expansion and make it a strategic priority to improve the health of Medicaid populations, especially those with complex health conditions.

Leadership in the Health Care Industry

We announced the selection of **B.J. Moore**, formerly of Microsoft, as Chief Information Officer in 2018 overseeing information services and partnering with other leading organizations in areas such as cloud computing and artificial intelligence.

Key Initiatives

Implementing improvement initiatives to respond to the changes in the industry. We are driving modernization and functional excellence by reimagining our structures, processes and practices, streamlining and improving access to tools and resources for our caregivers, and leverage our size to improve productivity.

Driving innovation through unconventional partnerships and new coalitions. We are investing to reinvent how we engage with our patients and deliver the best quality, highest-value health care to those we serve. For example, in order to increase access to care and offer a seamless patient experience, we formed a partnership with One Medical. This partnership provides complementary services through our Express Care platform, medical groups and ancillary services.

"We're excited to build upon our existing partnerships, as well as establish new ones that can help us advance our vision of Health for a Better World."
-Rod Hochman, M.D., President and CEO

Making profound breakthroughs in human health through systems biology. We are harnessing the potential of genomic, proteomic and biometric data to help patients improve their health. We are pioneering predictive modeling through our research affiliate, the Institute for Systems Biology (ISB), a biomedical research organization composed of a cross-disciplinary team of scientists with expertise in biology, technology, computer science, engineering, and bioinformatics. We are currently one of the leading health system practicing systems-driven medicine positioning us as a national and global leader among those inventing the future of healthcare. With 170 full-time scientists, researchers, and other talented staff from 30 countries, ISB has produced over 1,600 research publications since 2000, incubated over 19 spinout companies, and has generated over $445 million in grants and contracts revenue. Through ISB, we have formed partnerships, most recently with Seattle startup Arivale to explore how data-driven lifestyle coaching can prevent the advancement of Alzheimer's or reverse early symptoms of the disease. We seek to take a systems-driven approach to optimize health, and predict and prevent disease, and enable a sustainable environment both nationally and eventually globally.

Policy and advocacy

Advocating to improve individual and population health. We have made strides advocating on behalf of the millions of patients and customers we serve each year. In every state we serve, and at the national level, our system was a robust voice for preserving Medicaid coverage and the Affordable Care Act, which made possible the expansion of Medicaid. Our advocacy enabled expansion of telestroke – a key part of our telehealth strategy to reduce cost, and increased access and flexibility for patients. We were steadfast in advocating for accessible, affordable prescription drugs, including the 340B Drug Pricing Program, and essential generic medications. In 2018, we strongly advocated for the Veteran Affairs MISSION Act as it advanced through Congress and ultimately was passed into law. The legislation will allow us to better care for our veterans. We also advocated for the ACE Kids Act passed by the House of Representatives, which would improve care for children covered by Medicaid who have complex medical conditions, and is now with the Senate for consideration.

> *"We want to show people how Medicaid is a lifeline. And in most cases, it's a temporary lifeline for people to get back on their feet again"*
> ***-Ali Santore, Group Vice President of Government and Public Affairs***

We expect to see and respond to national policy trends toward narrowing coverage, reducing increasing medication costs, promoting a rapid transition to value-based care, and expanding health care price transparency. The Medicaid program is likely to add more maternal health services and pursue innovation with social determinants of health, while giving states further flexibility in Medicaid waivers. Medicare will also look at ways to enable housing and continue to find ways to reduce the administrative burden for providers. Across our states, Medicaid coverage and funding will be a leading topic for legislatures considering a host of budgetary priorities.

PSJH Enterprises

Using technology to improve patient engagement, caregiver productivity and reduce non-value added variation. We work to bring health care into the digital and consumer age through a persistent focus on patient and consumer value. We utilize digital tools to meet and engage patients where they live, deliver care on their terms, and establish a long-term dialogue about their health outside the wall of the exam room. We believe this strategy will lower the cost of care, generate new digital revenue streams, and unlock population health management capabilities and risk arrangements that help entire communities stay healthy.

Funding the future of health care through technology innovations. We founded Providence Ventures in 2014 to manage a $150 million venture capital fund designed to achieve venture class returns through direct investments in innovative health care companies that improve quality and convenience, lower cost and improve health outcomes. We offer investment capital, combined with health system expertise, to companies addressing existing and emerging pain points in health care. We partner with our portfolio companies to refine existing solutions, while expanding their adoption within and beyond our health system. In 2018, we launched a second $150 million fund, Providence Ventures II, to target early and growth-stage health care companies that specialize in health care information technology, technology-enabled services, medical devices, and health care services.

Driving transformational change with big data, blockchain, artificial intelligence and machine learning. Digital transformation will be increasingly important to empower patients to become more involved in their care as providers invest in cloud computing, artificial intelligence (AI) and machine learning, and consumer engagement platforms in health care. Population-based analytics are also providing opportunities to further evaluate and optimize care, and methods of health care delivery. We pass the benefits of our highly accessible, data-rich resources to our patients by identifying practices associated with lower costs and better outcomes. We have created a variety of systems built on AI and machine learning using our clinical data to transform care delivery for those we serve. Kyruus, a robust provider search and scheduling solution leverages our AI capabilities and empowers our consumers to find the right providers for their needs. We are also building a next-generation revenue cycle management platform using blockchain technology to transform how payers and providers share information and transact across the revenue cycle.

> *"New technologies like blockchain, artificial intelligence, and machine learning give us an opportunity to view the complexities of today's health systems through a different lens."*
> ***-Venkat Bhamidipati, EVP and CFO***

As we utilize our vast data resources to drive operational efficiency, we are optimizing our core electronic health records platform by aligning instances across ministries, representing our dedication to enhancing the patient experience across the continuum of care. We expect cost savings as standardization continues across all ministries, and partners, and anticipate these improvements will also allow our caregivers to serve our patients more efficiently. Our investment in a fully integrated patient system is consistent with our organizational growth strategy to utilize technology to operate more effectively across regions and provide a predictable, reliable experience for patients and caregivers, leading to consistent, high-quality care for those we serve.

Population Health Management

Making a transformational shift from health care to health. Our Population Health Management division is composed of a family of services, including Population Health Informatics, Payer & Provider Contracting, Value-Based Care, Care Management, Pacific Medical Centers and US Family Health Plan, Providence Health Plans and Ayin Health Solutions.

Population Health models and initiatives form a vital pillar in achieving our strategic plan of transforming care, delivering value based care, and creating healthier communities together. Our goal is to maximize the health outcomes of the people in our defined populations and communities through the design, delivery, and coordination of affordable quality health care and services. We integrate solutions to improve social determinants of health and provide care management for complex patients. We are building community partnerships to increase access to health services, transportation, housing, education, food banks, and mental health services.

Providence Health Plan (PHP) is a 501(c)(4) Oregon non-profit health care service contractor and Providence Health Assurance (PHA), a wholly-owned subsidiary of PHP are collectively referred to as the "Health Plans". Providence Plan Partners (PPP), is a 501(c)(4) Washington non-profit corporation. These three combined entities generated total revenues exceeding two billion and services to over one million lives in 2018.

Providence Health Plan provides services to a wide range of clients, including self-funded employers, and insurance coverage for large group employers, small group employers, individual and family coverage under the Affordable Care Act, Medicare Commercial, Medicare Advantage, Managed Medicaid risk administration, pharmacy benefits management, workers compensation services, and network access services under Providence Preferred plans.

Forming a new population health management company. We formed Ayin Health Solutions, a for-profit Delaware corporation, wholly-owned by PPP. Our new enterprise population heath management company will provide strategic consulting, administrative support and care coordination services for provider sponsored health plans, provider organizations, employers and state agencies with a strong focus on organizations serving Medicaid and Medicare patients. Ayin will serve as the population health engine to support the System's regional ministries and provide an avenue for revenue diversification through a for-profit, non-risk bearing entity. This strategy will improve the health outcomes in more of our communities and diversify our revenue streams.

"Population Health Management provides great opportunities to improve health outcomes, demonstrate value, and better manage health resources and costs. Through Ayin Health, this also presents an expanding area for revenue diversification and business growth"
-Rhonda Medows, M.D., President of Population Health Management and CEO of Ayin Solutions

Covenant Heath System (CHS) held a 67 percent beneficial membership interest in SHA, L.L.C., doing business as FirstCare Health Plans, a health maintenance organization operating in West/Central Texas. The remaining 33 percent of the membership interest was owned by Hendrick Medical Center ("Hendrick"), an unaffiliated not-for-profit corporation located in Abilene, Texas. In October 2018, CHS and Hendrick signed a definitive agreement with Scott and White Health Plan (SWHP) (part of Baylor Scott & White Health) pursuant to which SWHP would acquire FirstCare Health Plans. The transaction with SWHP closed on December 31, 2018, with CHS divesting all of its interest in FirstCare Health Plans as of that date.

Ambulatory Care Network

Providing an optimized and connected ambulatory experience for those we serve. We are focused on providing patients access to an optimized, lower cost, consumer-centric, connected ambulatory care network. We are currently providing over two million visits in our almost 200 sites across seven states, with a roadmap through 2022 to grow the network to serve five million visits in more than 500 sites. We are evolving our care delivery model with more than two million people served in an ambulatory network comprised of 44 ambulatory surgery centers, 51 imaging centers, 71 urgent care centers, and 43 retail clinics. We believe ambulatory networks offer advantages to patients and physicians, including greater affordability, predictability, flexibility, and convenience, while offering a seamless connection to our full continuum of care. This consumer-friendly approach is a key strategy to ensure we are the preferred health partner in the communities we serve. We are expanding our ambulatory care network throughout 2019 in strategic partnerships to improve access and reduce costs for consumers and employers, including increased same-day access through our retail and urgent care clinics. Our strategy is central to our vision of Health for a Better World, which focuses on how we deliver care in the right settings, and our efforts to sustain our Mission for the long term. We have made solid progress toward our commitment to being a partner in health.

Home & Community Care

Building out the continuum of care. As a trusted partner for individuals and families, our community-based care and services are geared to help in times of need, aging and illness, and at the end of life. We provide a full range of post-acute service, including assisted living, skilled nursing and rehabilitation, home health, home infusion and pharmacy services, home medical equipment, hospice and palliative care, Program of All-Inclusive Care for the Elderly (PACE) locations, supportive housing, and personal home care services. As our Mission calls us to serve the most vulnerable and poor members of our community, we provide a full range of services and support more to than 30,000 patients each day. We are experiencing strong growth in these services, creating opportunities for continued growth, innovation and investment.

Physician Enterprises

The System's physician enterprise consists of employed and foundation physicians, providers and their supporting care teams, including employed medical group providers, as well as hospital-based employed physicians. Our Employed Provider Network (the "Provider Network"), which is composed of eight provider service organizations, includes over 7,600 employed providers.

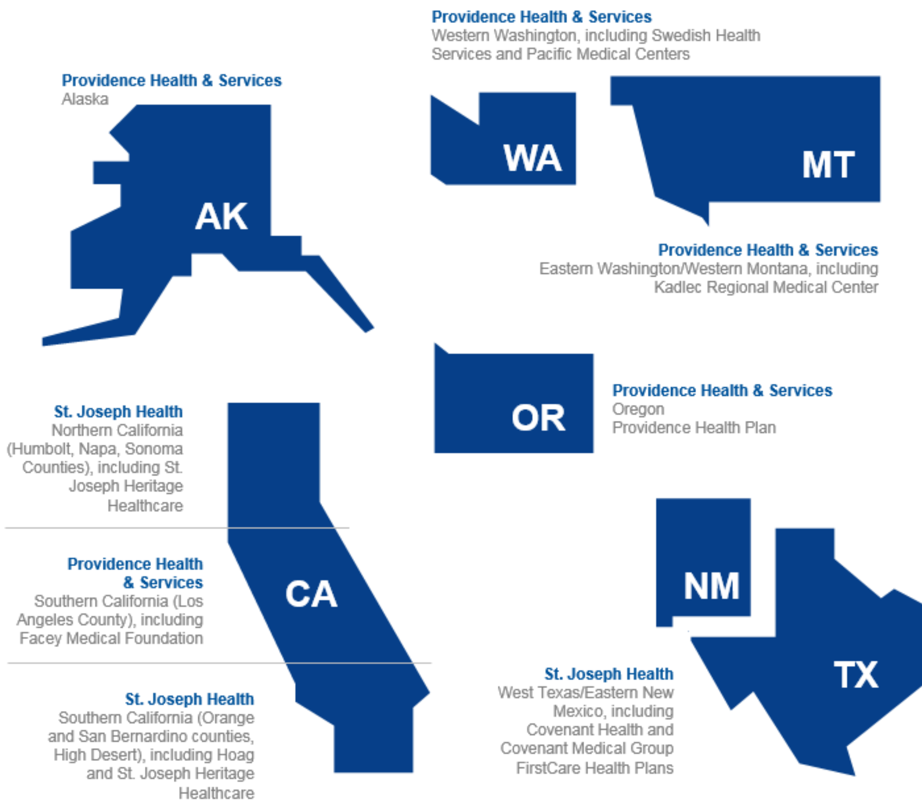
Medical groups and medical foundations within the Provider Network include: Providence Medical Group, a network serving Alaska, Washington and Montana, and Oregon; Swedish Medical Group, with

staffed clinics throughout Washington's greater Puget Sound area; Providence Medical Institute (PMI), in Southern California; Pacific Medical Centers, in western Washington; Kadlec Regional Medical Center (Kadlec), serving communities in southeast Washington; Providence St. John's Medical Foundation, in Southern California; Facey Medical Foundation (Facey), in Southern California; St. Joseph Heritage Healthcare, in Northern and Southern California; and Covenant Medical Group operating in West Texas and Eastern New Mexico. Supplementing our Provider Network are more than 24,000 affiliated providers throughout the System.

Health Care Facilities

We currently own, manage or operate hospitals, surgery centers, urgent care facilities, imaging centers, physician practices, pharmacies, home health services, rehabilitation facilities, a university and a high school, and various other facilities. We have contracted the servicing of certain facilities to allow us to continue our focus on areas that are central to serving our communities, while improving the quality of property management. Our facilities spans seven states across the western United States and include 51 acute care hospitals, 23 long-term care facilities, more than 973 clinics, and 16 supportive housing facilities. The System is organized into the geographic regions shown in the graphic below in Exhibit 1.1.

Exhibit 1.1



Region information

The System's operating revenue share by geographic region is presented for the years ended December 31:

EXHIBIT 1.2 - REGIONAL OPERATING REVENUE SHARE	2018	2017
Alaska	4%	4%
Swedish	11%	11%
Washington and Montana	20%	20%
Oregon	21%	21%
Northern California	6%	6%
Southern California	29%	29%
West Texas and Eastern New Mexico	6%	6%
Other	3%	3%

Alaska

As the largest health system in Alaska, the System operates 17 facilities throughout the state, with a 35 percent inpatient market share statewide in 2017. Providence Alaska Medical Center (PAMC) is the largest hospital in the state. The System's 17 Alaska facilities are located in the greater Anchorage area, with 60 percent inpatient market share. PAMC is a 401-bed acute care facility and the only comprehensive tertiary referral center in the state. St. Elias Specialty Hospital, a 59-bed long term acute hospital (the only one in the state) is also located in the Anchorage area. Three critical access hospitals are located in the remote communities of Kodiak, Seward and Valdez, all co-located with skilled nursing facilities.

Swedish

In the greater Puget Sound area of Washington, Swedish operates five hospital campuses: First Hill and Cherry Hill (in Seattle), Ballard, Edmonds and Issaquah located in King and Snohomish counties. The inpatient market share for Swedish was 27 percent in 2017. Swedish also has ambulatory care centers in Redmond and Mill Creek, and a network of more than 100 primary care and specialty clinics throughout the metropolitan corridor.

Washington and Montana

In the Washington-Montana region, the System operates 12 hospitals, with a 44 percent inpatient market share in 2017. The region is composed of five geographic markets: Northwest Washington, Southwest Washington, Eastern Washington, Southeast Washington and Western Montana, with Medical groups in the region employing over 2,000 providers. The region provides a variety of services, including home health care, primary and immediate care services, inpatient rehabilitation, and general acute care services.

Oregon

The Oregon region operates eight hospitals in Portland, Hood River, Medford, Milwaukie, Newberg, Seaside and Oregon City, with a total inpatient market share of 30 percent in 2017. Providence St. Vincent Medical Center provides tertiary care to the Portland metropolitan market. The region also provides more than 100 primary care, specialty and immediate care clinics, home health care, and housing. The Health Plans are based in Oregon, and a majority of its members (over 600,000) live in the region.

Northern California

The System's ministries in Northern California serve the North Coast, Humbolt, Napa and Sonoma communities with five hospitals, ambulatory surgery centers, urgent care centers, wellness centers, physician offices, home health, hospice, and rehab sites. The acute care hospitals in Northern California had 36 percent inpatient market share in 2017. St. Joseph Heritage Healthcare, a medical foundation, operates clinics in the region with its contracted the physician partners.

Southern California

The Southern California region includes 13 acute care hospitals in Los Angeles, Orange and San Bernardino counties, with a total inpatient market share of 24 percent in 2017. In Los Angeles County, the System operates six acute care facilities. Our largest hospital, Providence St. Joseph Medical Center, is located in Burbank. The System also operates hospitals in Mission Hills, San Pedro, Tarzana, Torrance and Santa Monica. Providence Medical Foundation (PMF) operates 63 practice locations in the market, offering more than 20 types of specialty care. PMF includes the Facey, PMI and Providence St. John's medical foundations, In addition, the System operates seven acute care facilities within Orange and San Bernardino counties: Apple Valley, Fullerton, Mission Viejo, Laguna Beach, Newport Beach, Irvine and Orange. Mission Hospital is located on two campuses in Mission Viejo and Laguna Beach and maintains the region's level II trauma center, as well as a women's center. Hoag Hospital, which is also composed of two campuses, in Newport Beach and Irvine, also includes Hoag Orthopedic Institute, part of St. Joseph Hoag Health alliance. St. Joseph Heritage Healthcare, a medical foundation, operates clinics in the region with its contracted the physician partners.

West Texas and Eastern New Mexico

The West Texas-Eastern New Mexico region includes Covenant Health System and Covenant Medical Group. Covenant is the market's largest health system with seven licensed hospitals; the inpatient market share was 38 percent in 2017. The System also operates Grace Heath System which includes Grace Clinic and Grace Medical Center, Covenant Medical Group, a medical foundation physician network of employed and aligned physicians. Covenant Health Partners, a physician-hospital cooperative organization based in Lubbock, Texas, operates two acute care community hospitals in the region: Covenant Health Plainview and Covenant Health Levelland. Finally, Covenant also operates: Specialty Hospital, a long-term acute care facility; manages a joint ventured acute rehabilitation facility; and operates Hospice of Lubbock.

Obligated group

The System and the entities listed in the following table (collectively, the "Obligated Group") are currently members of the Obligated Group under the Master Trust Indenture (Amended and Restated), dated as of May 1, 2003 (as supplemented and amended, the "Master Indenture") as shown in Exhibit 2.1 below.

Exhibit 2.1 - List of Obligated Group Members

Obligated Group Member	Incorporation	Reference
Providence St. Joseph Health	Washington nonprofit	*"System"*
Providence Health & Services	Washington nonprofit	"*PH&S*"
Providence Health & Services – Washington	Washington nonprofit	"*Providence - Washington*"
Providence Health System – Southern California	California nonprofit religious	"*Providence - Southern California*"
Little Company of Mary Ancillary Services Corporation	California nonprofit public benefit	"*LCMASC*"
Providence Saint John's Health Center	California nonprofit religious	"*Providence - Saint John's*"
Providence St. Joseph Medical Center	Montana nonprofit	"*Providence - SJMC Montana*"
Providence Health & Services – Montana	Montana nonprofit	"*Providence - Montana*"
Providence Health & Services – Oregon	Oregon nonprofit	"*Providence - Oregon*"
Providence Health & Services – Western Washington	Washington nonprofit	"*Providence - Western Washington*"
Swedish Health Services	Washington nonprofit	"*Swedish*"
Swedish Edmonds	Washington nonprofit	"*Swedish Edmonds*"
PacMed Clinics	Washington nonprofit	"*PacMed*"
Western HealthConnect	Washington nonprofit	"*Western HealthConnect*"
Kadlec Regional Medical Center	Washington nonprofit	"*Kadlec*"
St. Joseph Health System	California nonprofit public benefit	"*SJHS*"
St. Joseph Hospital of Orange	California nonprofit public benefit	"St. *Joseph Orange*"
St. Jude Hospital, Inc. (1)	California nonprofit public benefit	"*St. Jude*"
Mission Hospital Regional Medical Center	California nonprofit public benefit	"*Mission Hospital*"
St. Mary Medical Center	California nonprofit public benefit	"*St. Mary*"
Hoag Memorial Hospital Presbyterian	California nonprofit public benefit	"*Hoag Hospital*"
St. Joseph Health Northern California, LLC.	California limited liability company	*"SJHNC"*
Queen of the Valley Medical Center	California nonprofit public benefit	*"Queen of the Valley"*
Santa Rosa Memorial Hospital	California nonprofit public benefit	*"Santa Rosa Memorial"*

St. Joseph Hospital of Eureka	California nonprofit public benefit	*"St. Joseph Eureka"*
Redwood Memorial Hospital of Fortuna	California nonprofit public benefit	*"Redwood Memorial"*
Covenant Health System	Texas nonprofit	"*CHS*"
Covenant Medical Center	Texas nonprofit	*"CMC"*
Methodist Children's Hospital [(2)]	Texas nonprofit	"*Covenant Children's*"
Methodist Hospital Levelland [(3)]	Texas nonprofit	"*Covenant Levelland*"
Methodist Hospital Plainview [(4)]	Texas nonprofit	"*Covenant Plainview*"

[(1)] Doing business as St. Jude Medical Center
[(2)] Doing business as Covenant Children's Hospital
[(3)] Doing business as Covenant Hospital Levelland
[(4)] Doing business as Covenant Hospital Plainview

The System is the Obligated Group Agent under the Master Indenture. Under the Master Indenture, debt incurred or secured through the issuance of Obligations under the Master Indenture are the responsibility, jointly and severally, of the Obligated Group Members. Pursuant to the Master Indenture, Obligated Group Members may be added to and withdrawn from the Obligated Group under certain conditions described in the Master Indenture. INDEBTEDNESS EVIDENCED OR SECURED BY OBLIGATIONS ISSUED UNDER THE MASTER INDENTURE IS SOLELY THE OBLIGATION OF THE OBLIGATED GROUP, AND SUCH OBLIGATIONS ARE NOT GUARANTEED BY, OR THE LIABILITIES OF, SISTERS OF PROVIDENCE, MOTHER JOSEPH PROVINCE, ANY OTHER PROVINCE OF THE SISTERS OF PROVIDENCE MONTREAL CONGREGATION, THE LITTLE COMPANY OF MARY SISTERS, AMERICAN PROVINCE, SISTERS OF ST. JOSEPH OF ORANGE, THE ROMAN CATHOLIC CHURCH, OR ANY AFFILIATE OF THE SYSTEM THAT IS NOT AN OBLIGATED GROUP MEMBER.

Outstanding Master Trust Indenture Obligations

As of December 31, 2018, the System has 46 Obligations outstanding under the Master Trust Indenture totaling $6,131,000,000. This excludes obligations that secure interest rate or other swap transactions, bank liquidity or credit facilities, and capital leases. The obligations outstanding under the Master Trust Indenture relating to tax-exempt and taxable bond/note indebtedness are described further in the Notes to the Combined Audited Financial Statements for the twelve-month period ended December 31, 2018.

For the year ended December 31, 2018, the audited combined net operating revenue and total assets attributable to the Obligated Group Members were approximately 82 percent and 87 percent, respectively, of the System totals. For the year ended December 31, 2017, the audited combined net operating revenues and total assets attributable to the Obligated Group Members were approximately 83 percent and 88 percent, respectively, of the Systems totals. Refer to Exhibit 7 for voluntary supplemental information on the Obligated Group Members.

Utilization for the Obligated Group

A summary of certain acute care utilization data for the Obligated Group is presented for the years ended December 31:

EXHIBIT 2.2 - DATA PRESENTED YEAR TO DATE; IN THOUSANDS UNLESS NOTED	2018	2017
Obligated Group		
Total Acute Admissions	504	516
Acute Patient Days	2,395	2,391
Long-term Patient Days	402	387
Outpatient Visits (incl. Physicians)	21,450	20,899
Emergency Room Visits	2,089	2,119
Total Surgeries and Procedures	561	558
Acute Average Daily Census (actual)	6,562	6,552

Non-obligated group system affiliates

In addition to the Obligated Group Members, the System includes: health plans; a provider network; numerous fundraising foundations; Providence Ventures, Inc., a Washington corporation that invests in health care activities; various not-for-profit corporations that own and operate assisted living facilities and

low-income housing projects, including housing facilities for the elderly; and the University of Providence formerly known as University of Great Falls, located in Great Falls, Montana. The System also includes multiple operations involving or supporting home health, outpatient surgery, imaging services and other professional services provided through for-profit and non-profit entities that are not part of the Obligated Group. These entities are organized as subsidiaries of the System, partnerships or joint ventures with other entities. Obligated Group Members also may engage in informal alliances and/or contract-based physician relationships. Affiliates that are not Obligated Group Members are referred to in this Annual Report as the "*Non-Obligated Group System Affiliates*." Certain Non-Obligated Group System Affiliates that are of significant operational or strategic importance and other Non-Obligated Group System Affiliates are discussed elsewhere in this Annual Report only to the extent they are viewed by System management to be of particular operational or strategic importance.

Financial information

The summary audited combined financial information as of and for the fiscal years ended December 31, 2018 and 2017, respectively, are presented below. The financial information should be read in conjunction with the audited combined financial statements of the System, including the notes thereto, and the report of KPMG LLP, independent auditors.

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make assumptions, estimates and judgments that affect the amounts reported in the combined financial statements, including the notes thereto, and related disclosures of commitments and contingencies, if any. System management considers critical accounting policies to be those that require the more significant judgments and estimates in the preparation of its financial statements, including the following: recognition of net operating revenues, which includes contractual allowances; impairment of long-lived assets; valuation of investments; accounting for expenses in connection with restructuring activities; provisions for bad debt; and reserves for losses and expenses related to health care professional and general liability risks. Management relies on historical experience and on other assumptions believed to be reasonable under the circumstances in making its judgments and estimates. Actual results could differ materially from those estimates.

Summary Audited Combined Statements of Operations

EXHIBIT 3.1 - DATA PRESENTED YEAR TO DATE; PRESENTED IN MILLIONS	2018	2017	VARIANCE
Net Patient Service Revenues	18,998	17,867	1,131
Premium and Capitation Revenues	4,359	4,079	280
Other Revenues	1,071	1,217	(146)
Total Operating Revenues	**24,428**	**23,163**	**1,265**
Salaries, Wages and Other	22,903	21,853	1,050
Depreciation	1,082	1,038	44
Interest and Amortization	278	269	9
Total Operating Expenses Before Restructuring Costs	**24,263**	**23,160**	**1,103**
Excess of Revenues Over Expenses from Operations Before Restructuring Costs	**165**	**3**	**162**
Restructuring Costs	162	-	162
Excess of Revenues Over Expenses from Operations	**3**	**3**	**-**
Net Non-operating (Losses) Gains	(448)	777	(1,225)
(Deficit) Excess of Revenues Over Expenses	**(445)**	**780**	**(1,225)**
Operating EBIDA	**1,363**	**1,310**	**53**
Pro Forma Operating EBIDA [1]	**1,525**	**1,209**	**316**

[1] Pro forma operating EBIDA normalizes for one-time anomalies, including restructuring costs of $162 million in 2018 and the PAML transaction in 2017 of $101 million

Summary Audited Combined Balance Sheets

EXHIBIT 3.2 - PRESENTED IN MILLIONS	2018	2017	VARIANCE
ASSETS			
Current Assets:			
Cash and Cash Equivalents	1,597	1,371	226
Short-term Investments	511	414	97
Accounts Receivable, Net	2,257	2,222	35
Other Current Assets	1,151	1,434	(283)
Current Portion of Funds Held by Trustee	143	66	77
Total Current Assets	**5,659**	**5,507**	**152**
Assets Whose Use Is Limited:			
Long-term Investments	9,135	9,526	(391)
Other Restricted Assets	464	460	4
Total Assets Whose Use Is Limited	**9,599**	**9,986**	**(387)**
Property, Plant and Equipment, Net	10,871	10,955	(84)
Total Other Assets	1,300	1,197	103
Total Assets	**27,429**	**27,645**	**(216)**
LIABILITIES AND NET ASSETS			
Current Liabilities:			
Master Trust Debt classified as Short-term	110	57	53
Accounts Payable	1,098	684	414
Accrued Compensation	1,202	1,111	91
Other Current Liabilities	2,135	2,369	(234)
Total Current Liabilities	**4,545**	**4,221**	**324**
Long-term Debt, Net of Current Portion	6,258	6,485	(227)
Other Long-term Liabilities	2,235	2,193	42
Total Liabilities	**13,038**	**12,899**	**139**
Net Assets:			
Net Assets without Donor Restrictions	13,156	13,545	(389)
Net Assets with Donor Restrictions	1,235	1,201	34
Total Net Assets	**14,391**	**14,746**	**(355)**
Total Liabilities and Net Assets	**27,429**	**27,645**	**(216)**

Introduction to Management's Discussion and Analysis

Management's discussion and analysis provides additional narrative explanation of the financial condition, operational results and cash flow of the System to assist in increasing understanding of the combined financial statements. The audited combined financial information as of and for the fiscal years ended December 31, 2018 and 2017, respectively, are presented below. The following document is incorporated herein by reference and are available for review on the Electronic Municipal Market Access (*EMMA*) website of the Municipal Securities Rulemaking Board (*MSRB*): *Providence St. Joseph Health, Continuing Disclosure Annual Report, including Management's Discussion and Analysis and Results of Operations, Fiscal Year Ended December 31, 2018.*

Results of operations

Operations Summary

Operating earnings before interest, depreciation and amortization (EBIDA) was $1.4 billion and operating income was $3 million for the year ended December 31, 2018, compared with $1.3 billion and $3 million, respectively, in the same period for 2017 (as reported), and includes $162 million for restructuring costs comprised of asset impairment, severance, and consulting expenses as part of a system-wide effort to streamline operations and improve productivity. Pro forma operating EBIDA, normalized for restructuring costs in 2018 and the gain related to sale of Pathology Associates Medical Laboratories, LLC (PAML) in 2017, increased $316 million and $263 million, respectively, for the year ended December 31, 2018, compared with the same period in 2017. The net increase was driven by overall higher acuity and volumes growth, increased rates in outpatient and inpatient settings, improvements from expense reduction initiatives, and higher labor productivity. The increase in volumes drove corresponding increases in labor and supply costs. Operating EBIDA before restructuring costs was also impacted by the recognition of provider tax programs in 2018. The System's key financial indicators are presented below both as reported and pro forma for the years ended December 31:

	AS REPORTED			PRO FORMA [1]		
EXHIBIT 3.3 - DATA PRESENTED YEAR TO DATE; $ FIGURES PRESENTED IN MILLIONS	2018	2017	VARIANCE	2018	2017	VARIANCE
Operating Income (Loss)	3	3	-	165	(98)	263
Operating Margin %	0.0	0.0	0.0	0.7	(0.4)	1.1
Operating EBIDA	1,363	1,310	53	1,525	1,209	316
Operating EBIDA Margin %	5.6	5.7	(0.1)	6.2	5.2	1.0
Net Service Revenue/Case Mix Adjusted Admits	12,066	11,652	414	12,066	11,548	518
Expense/Case Mix Adjusted Admits	12,064	11,650	414	11,902	11,647	255
Debt to Cash Flow	7.0	3.1	3.9	5.9	3.3	2.6
Total Community Benefit (millions)	1,595	1,601	(6)	-	-	-
Full-time Equivalents (thousands)	105	103	2	-	-	-

[1] 2018 pro forma normalizes for restructuring costs, including $162 million for operating expenses, operating income and operating EBIDA; and 2017 normalizes for the PAML transaction, including $104 million for operating revenues, $3 million for operating expenses, and $101 million for operating income and operating EBIDA

Volumes

The System experienced four percent higher volumes per case mix adjusted admissions (CMAA) for the year ended December 31, 2018, compared with the same period in 2017, driven by growth in the outpatient setting and increased patient acuity. Outpatient visits grew five percent for the year ended December 31, 2018, compared with the same period in 2017, primarily due to a nine percent increase in the physician visits. The System's key volume indicators are presented for the years ended December 31:

EXHIBIT 3.4 - DATA PRESENTED YEAR TO DATE	2018	2017	VARIANCE
Inpatient Admissions	514	522	(8)
Acute Adjusted Admissions	1,025	1,002	23
Acute Patient Days	2,441	2,420	21
Long-term Patient Days	413	399	14
Outpatient Visits (incl. Physicians)	26,915	25,648	1,267
Emergency Room Visits	2,108	2,119	(11)
Total Surgeries and Procedures	625	613	12
Acute Average Daily Census (actual)	6,688	6,631	57
Providence Health Plan Members	648	648	-

The Providence Health Plan enrollment remained consistent compared with the prior year. Connected lives member months, a measure of the number of individuals participating in the plan each month, were eight million for the Providence Health Plan, an increase of two percent for the year ended December 31, 2018, compared with the same period in 2017.

Operating Revenues

Operating revenues for the year ended December 31, 2018 was $24 billion, an increase of five percent, compared with the same period in 2017, driven by higher patient volumes and higher acuity levels. Capitation and premium revenues represented 18 percent of total operating revenues, and grew seven percent for the year ended December 31, 2018, compared with the same period in 2017. The System's operating revenues by state is presented for the years ended December 31:

EXHIBIT 3.5 - OPERATING REVENUES BY STATE (1)	2018	2017	VARIANCE
Alaska	851	818	33
Washington	6,724	6,550	174
Montana	433	415	18
Oregon	5,091	4,791	300
California	8,684	7,966	718
Texas	1,574	1,406	168
Total Revenues from Contracts with Customers	23,357	21,946	1,411
Other Revenues	1,071	1,217	(146)
Total Operating Revenues	24,428	23,163	1,265

The System's operating revenues by line of business is presented for the years ended December 31:

EXHIBIT 3.6 - OPERATING REVENUES BY LINE OF BUSINESS [1]	2018	2017	VARIANCE
Hospitals	16,187	15,344	843
Heath Plans and Accountable Care	3,212	2,993	219
Physician and Outpatient Activities	2,726	2,451	275
Long-term Care, Home Care, and Hospice	990	845	145
Other	242	313	(71)
Total Revenues from Contracts with Customers	23,357	21,946	1,411
Other Revenues	1,071	1,217	(146)
Total Operating Revenues	24,428	23,163	1,265

Net patient revenues per case mix adjusted admissions increased four percent for the year ended December 31, 2018, compared with the same period in 2017. As a percent of total net patient revenues, Medicaid increased compared with the prior year mostly from an increase in Medicaid revenues from the recognition of provider tax programs in 2018. The System's net patient revenues by payor mix is presented for the years ended December 31:

EXHIBIT 3.7 - PAYOR NET PATIENT REVENUES [1]	2018	2017	VARIANCE
Commercial	11,503	11,041	462
Medicare	7,540	7,311	229
Medicaid	3,781	3,041	740
Self-pay and Other	533	553	(20)
Total Revenues from Contracts with Customers	23,357	21,946	1,411
Other Revenues	1,071	1,217	(146)
Total Operating Revenues	24,428	23,163	1,265

(1) Prepared in accordance with U.S. GAAP upon adoption of ASC 606, Revenue from Contracts with Customers

Operating Expenses

Operating expenses for the year ended December 31, 2018 were $24 billion, an increase of five percent compared with the same period in 2017, driven mainly by costs associated with serving the System's higher volumes, restructuring charges, and adjustments related to the California provider tax program. Restructuring costs related to asset rationalization, employee reductions and other items were incurred to drive future operating performance. Salaries and wages expense increased four percent for the year ended December 31, 2018, compared with the same period in 2017, driven by full-time equivalent ("FTE") growth of two percent. On an adjusted occupied bed volumes basis, labor productivity improved three percent, compared with the prior year. Supplies expense increased five percent for the year ended December 31, 2018, driven primarily by a 10 percent increase in pharmaceutical spend offset by a two percent decline in medical supply costs per CMAA compared with the prior year.

Non-Operating Activity

Non-operating activity is primarily comprised of investment income, pension settlement costs, and expenses for innovation projects. Non-operating losses totaled $448 million for the year ended December 31, 2018, compared with non-operating gains of $777 million for the same period in 2017. The decrease was primarily driven by weaker market performance for the year ended December 31, 2018, compared with relatively strong market performance over the same period in 2017.

Liquidity and capital resources

Unrestricted Cash and Investments

Unrestricted cash reserves totaled over $11.2 billion as of December 31, 2018, compared to $11.3 billion for the prior year, and includes cash generated from operations, debt service costs, capital spending and investment activity. The System's liquidity of the System is presented for the years ended December 31:

EXHIBIT 4.1 - DATA PRESENTED YEAR TO DATE	2018	2017	VARIANCE
Cash and Cash Equivalents	1,597	1,371	226
Short-term Investments	511	414	97
Long-term Investments	9,135	9,526	(391)
Total Unrestricted Cash and Investments	11,243	11,311	(68)

The System maintains a long-term investment program (the "Program") comprised of three funds: the health care facilities, the foundations and PHP, respectively. Each fund may maintain its own investment and asset allocation policies. The table below includes the target asset allocation of the Program investment portfolio, by general asset class, for the years ended December 31:

EXHIBIT 4.2 - DATA PRESENTED YEAR TO DATE	2018	2017	VARIANCE
Cash and Cash Equivalents	2%	2%	-
Domestic and International Equities	45%	45%	-
Debt Securities	33%	33%	-
Other Securities	20%	20%	-

Financial Ratios

The System's financial ratios is presented for the years ended December 31:

EXHIBIT 4.3 - DATA PRESENTED YEAR TO DATE	2018	2017	VARIANCE
Total Debt to Capitalization %	32.6	32.6	(0.0)
Current Debt Service Coverage	4.4	3.3	1.1
Cash to Debt Ratio %	176.6	172.9	3.7
Cash to Comprehensive Debt %	118.4	114.4	4.0
Days Cash on Hand (1)	178	189	(11)
Cushion Ratio	29	29	-
Maximum Annual Debt Service ("MADS")	390	384	6
Comprehensive Debt to Capitalization %	41.9	42.2	(0.3)
Cash to Total Net Asset Ratio	0.85	0.84	0.01

(1) Day Cash on Hand, a measure of cash in relation to monthly operating expenses, is calculated as follows: (Unrestricted cash & investments) / ((total operating expenses - depreciation and amortization expenses)/days outstanding during the periods. The years presented were restated to normalize for one-time anomalies.

Capitalization

The System's capitalization of the System is presented for the years ended December 31:

EXHIBIT 4.4 - DATA PRESENTED YEAR TO DATE; $ FIGURES PRESENTED IN MILLIONS	2018	2017	VARIANCE
Long-term Indebtedness	6,558	6,564	(6)
Less: Current Portion of Long-term Debt	300	79	221
Net Long-term Debt	6,258	6,485	(227)
Net Assets - Unrestricted	13,156	13,545	(389)
Total Capitalization	19,414	20,030	(616)
Long-term Debt to Capitalization %	32.2%	32.4%	(0.2%)

The System's coverage of MADS on indebtedness is presented for the years ended December 31:

EXHIBIT 4.5 - DATA PRESENTED YEAR TO DATE; $ FIGURES PRESENTED IN MILLIONS	2018	2017	VARIANCE
Income Available for Debt Service:			
(Deficit) Excess of Revenues Over Expenses	(445)	780	(1,225)
Plus: Unrealized Losses/Less: Unrealized (Gains) on Trading Securities	652	(595)	1,247
Plus: Loss on Extinguishment of Debt	6	-	6
Plus: Loss on Pension Settlement Costs and Other	26	25	1
Plus: Depreciation	1,082	1,038	44
Plus: Interest and Amortization	278	269	9
Total	1,599	1,517	82
Debt Service Requirements [(1)]:			
MADS	390	384	6
Coverage of Debt Service Requirements	4.1x	4.0x	0.1

[(1)] Debt Service Requirements has the meaning assigned to such term in the Master Indenture.

Credit Agency Ratings

The System received affirmation on the following ratings from the three national credit rating agencies conducted during their annual review at the end of 2017 and issued the following credit ratings:

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

Governance and management

Corporate Governance

The System serves as the parent and corporate member of PH&S and SJHS. The System has obtained tax exemption under Section 501(c)(3) of the Internal Revenue Code. Prior to the Combination, the sole corporate member of PH&S was Providence Ministries, which acted through its sponsors, who are five individuals appointed by the Provincial Superior of the Sisters of Providence, Mother Joseph Province. Similarly, the sole corporate member of SJHS was St. Joseph Health Ministry, a California non-profit public benefit corporation. Providence Ministries and St. Joseph Health Ministry are each a public juridic person under Canon law, responsible for assuring the Catholic identity and fidelity to the mission of their respective Systems. Pursuant to the Combination, Providence Ministries and St. Joseph Health Ministry have entered into an agreement that establishes a sponsorship model through contractual obligations exercised by the parties' sponsors collectively (the "Sponsors Council"). The Sponsors Council retains certain reserved rights with respect to the System. Among the powers reserved to the Sponsors Council are the following powers over the affairs of the System (excluding certain affiliates, such as: Providence - Western Washington, Western HealthConnect, Swedish, Swedish Edmonds, PacMed, Kadlec and Hoag Hospital): to amend or repeal the articles of incorporation or bylaws of the System; the appointment and removal, with or without cause, of the directors of the System; the appointment and removal, with or without cause, of the President and Chief Executive Officer of the System; the approval of the acquisition of assets, incurrence of debt, encumbering of assets and sale of certain property of the System; the approval of operating and capital budgets, upon recommendation of the System Board of Directors; and the approval of dissolution, consolidation or merger. The System has reserved rights over PH&S and SJHS, which powers may be exercised by Board of the System.

The following table lists the current members of the Board of Directors and the Sponsors Council.

Board of Directors	Term Expires (December 31)	Sponsors Council	Term Expires (December 31)
Richard Blair, Chair †	2019	Eleanor Brewer	2020
David Olsen, Vice Chair ‡	2019	Ned Dolejsi	2019
Dick Allen ‡	2019	Jeff Flocken	2019
Isiaah Crawford, PhD Δ	2019	Barbara Savage	2019
Lucille Dean, SP †	2019	Bill Cox	2022
Diane Hejna, CSJ, RN. Δ	2019	Russell Danielson	2021
Michael Holcomb ‡	2019	Sr. Sharon Becker, CSJ	2021
Phyllis Hughes, RSM, PhD. Δ	2019	Sr. Barbara Schamber, SP	2019
Sallye Liner, MSN, RN †	2019	Sr. Katherine Gray, CSJ	2019
Mary Lyons, PhD. Δ	2019	Mark Koeing	2021
Walter "Bill" Noce, Jr. †	2019		
Carolina Reyes, M.D. Δ	2019		
Phoebe Yang Δ	2019		
Rod Hochman, M.D.	Ex-officio		

† Not eligible for an additional term.
‡ Eligible for one additional three-year term.
Δ Eligible for up to two.

Executive Leadership Team

The following leaders are members of our executive leadership team, reporting to the CEO of the System.

Name	Title
Rod Hochman, M.D.	President and CEO
Venkat Bhamidipati	EVP and CFO
Mike Butler	President of Operations and Strategy
Debra Canales	EVP and Chief Administrative Officer
Amy Compton-Phillips, M.D.	EVP and Chief Clinical Officer
Dougal Hewitt	EVP and Chief Mission Officer
Rhonda Medows, M.D.	President of Population Health Management and CEO of Ayin Solutions
Cindy Strauss	EVP and Chief Legal Officer
Sheryl Vacca	SVP and Chief Risk Officer

Support Services

Corporate officers and supporting staff oversee the management activities carried on, on a day-to-day basis, by the management staff of each region. Each regional Chief Executive reports to the President of Operations, who oversees their management with emphasis on the service area's achievements in responding to unmet health care needs in the community, especially the unmet needs of the poor, productivity, developing integrated delivery systems, meeting financial guidelines, and maintaining or increasing market share. The Chief Financial Officer of the System and Finance staff coordinate the annual budget and five-year forecasts (also updated annually) of the service areas, and manage the capital acquisition and management activities of the Obligated Group. Other areas in which the corporate staff provides centralized services or coordinates the activities of the service areas include: legal affairs, insurance and risk management, treasury services, materials management, technical support, fund raising, quality of care, medical ethics, pastoral services, mission effectiveness, human resources, planning and policy development, and public affairs.

Control of Certain Obligated Group Members

General

PH&S is the sole corporate member, directly or indirectly, of each of Providence – Washington, Providence – Southern California, LCMASC, Providence – St. John's, Providence – SJMC Montana, Providence – Montana, Providence – Oregon, Swedish, Swedish Edmonds, Pac Med, Western Health Connect and Kadlec, and co-corporate member of Providence – Western Washington.

SJHS is the sole corporate member of Redwood Memorial, St. Joseph Eureka, Santa Rosa Memorial and Queen of the Valley and, as more fully described hereinafter, a corporate member of St. Joseph Orange, St. Jude, Mission Hospital and St. Mary.

Northern California Region

SJHS is the sole member of St. Joseph Health Northern California, LLC, which as of April 1, 2018, operates and does business as Santa Rosa Memorial Hospital, Queen of the Valley Medical Center, St. Joseph Hospital of Eureka, and Redwood Memorial Hospital (the "Hospitals"). The Hospitals' corporations still exist with minimal operations. The goal is to dissolve these corporations by the end of the first quarter of 2019. St. Joseph Health Northern California, LLC, is also the sole member of SRM Alliance Hospital Services, which operates Petaluma Valley Hospital.

Southern California Region

In connection with the March 2013 affiliation of SJHS and Hoag Hospital, a new entity known as Covenant Health Network, Inc. (CHN), a California nonprofit public benefit corporation, was created. CHN is a corporate member of Hoag Hospital and St. Joseph Orange, St. Jude, Mission Hospital and St. Mary (the "SJHS Southern California Hospitals"). CHN, The George Hoag Family Foundation ("Hoag Family Foundation") and the constituent churches of the Los Ranchos Presbytery of the Presbyterian Church (USA), as represented by the Association of Presbyterian Ministers (APM), are the corporate members of Hoag Hospital. None of CHN, Hoag Family Foundation or APM is an Obligated Group Member or is obligated for payment on the Series 2018 Bonds.

SJHS, CHN, Hoag Hospital and the SJHS Southern California Hospitals entered into an affiliation pursuant to the terms of an Affiliation Agreement dated as of October 15, 2012 (the "CHN Affiliation Agreement"). The CHN Affiliation Agreement, which became effective as of March 1, 2013, is designed to allow SJHS and each of the SJHS Southern California Hospitals on the one hand, and Hoag Hospital on the other hand, to preserve their respective Catholic and Presbyterian heritages and identities while creating an integrated community health care delivery system. The Affiliation Agreement was amended June 1, 2017 and the System became a party to the arrangement. In addition, a Supplemental Agreement and two amendments were also entered into between the parties in 2017.

CHN does not have any corporate members, and neither the System, SJHS, its affiliates, nor Hoag Hospital have any ownership interest in CHN. CHN's governing board consists of seven members, four of whom are designated by the System. The remaining three members are designated by Hoag Family Foundation and APM, acting collaboratively. In accordance with the CHN Affiliation Agreement and its amendments and supplements, the System shall at all times have the right to designate at least a majority of the CHN board members. The CHN board is principally responsible for providing strategic planning leadership and oversight for each of Hoag Hospital, the SJHS Southern California Hospitals.

CHN and SJHS have certain reserved powers with respect to the governance, management and operation of each of the SJHS Southern California Hospitals and Hoag Hospital. Some of these powers may be exercised only by a supermajority vote of the CHN Board of Directors, meaning the affirmative vote of at least three of the four members designated by the System, and of at least two of the three members designated by Hoag Family Foundation and APM. These reserved powers include, among others, certain actions relating to: (i) changes in articles and bylaws, (ii) certain board member and management appointments and removals; and (iii) certain hospital mergers, acquisitions, joint ventures, asset sales, cash transfers and financings. Hoag Family Foundation and APM also have reserved powers with respect to certain management and operating matters and transactions involving Hoag Hospital.

West Texas/Eastern New Mexico Region

SJHS and Lubbock Methodist Hospital System (LMHS) are the corporate members of CHS. CHS is the sole corporate member of Covenant Children's, Covenant Levelland and Covenant Plainview. LMHS is not an Obligated Group Member and is not obligated for payment on the Series 2018 Bonds.

CHS was formed in 1998 pursuant to an affiliation between SJHS and LMHS and its affiliates, pursuant to which CHS became the sole corporate member of certain entities previously affiliated with LMHS and, together with certain of such entities, joined the obligated group to which SJHS and its affiliates were party.

CHS is governed by a 19-member board of directors. LMHS and SJHS each appoint eight directors. SJHS also appoints the Chief Executive Officer of CHS, who is an ex-officio voting director. The CHS Chief of Staff and Covenant Children's Hospital Chief of Staff also serve as ex-officio voting directors. SJHS has extensive authority with respect to the financial affairs of CHS and its subsidiaries, including, but not limited to, the approval of budgets of CHS and its subsidiaries and selection and retention of auditors.

As part of the affiliation, SJHS, CHS and LMHS entered into an agreement that significantly restricts the ability of SJHS to sever its relationship with CHS and the entities formerly affiliated with LMHS. Under certain circumstances, it also restricts CHS and SJHS from a wide variety of transactions (the "Covered Transactions"), including: (i) certain management agreements, leases, joint ventures and other transactions that might have the effect of transferring control of Covenant Medical Center or all assets of CHS and its subsidiaries to an unrelated third party, or in a manner that voids or reduces LMHS's right, as a member, to appoint directors; (ii) a sale, transfer or conveyance of all or substantially all of CHS' assets (including all of CHS' affiliates, taken in the aggregate); (iii) an affiliation, management agreement, lease or joint venture under which a third party acquires the right to control CHS, as a whole; or (iv) any other transaction in which the ability to appoint and remove more than 50 percent of the directors of CHS is transferred to a third party.

In the event SJHS or CHS undertakes a Covered Transaction, they are obligated to provide notice and information to LMHS and to make a "reciprocal offer" to LMHS, including an offer to purchase LMHS's membership rights in CHS and a simultaneous obligation to offer CHS' membership rights to LMHS at the same purchase price, adjusted upward by a formula that reflects the dissolution percentages Pursuant to the terms of the affiliation, the dissolution percentages are SJHS – 57 percent; LMHS – 43 percent.

Other information

Employees

As of December 31, 2018, the System employed approximately 115,000 caregivers (excluding Hoag), which represents approximately 105,000 FTEs. Of the total employees in the System, approximately 32 percent are represented by 17 different labor unions.

Management of the System believes the salary levels and benefits packages for its employees are competitive in all of the respective markets. At the same time, management of the System knows that the health care market is rapidly evolving. As a result, the leadership of each of the separate employers within the System is working to ensure the compensation and benefits are modern and reflect competitive market practices, which will require negotiations at various employers within the System in the first six months of 2019. In the past two years, the System has experienced strikes at different facilities, as a result of contract negotiations. In each situation, the facility operated with qualified replacement employees and did not experience any disruption to hospital operations or patient service, and ultimately settled the contract. Management is also aware of ongoing organizing efforts by labor unions in health care generally, particularly in the markets where the System operates, and at other employers in certain markets in the System.

Insurance

The System has developed insurance programs that provide coverage for the vast majority of insurable risks. The program uses benchmarking and insurance analytics to guide its decisions regarding both the type of coverage it purchases and the limits of that insurance. The analytics use claims and historical data to estimate the likelihood of certain events occurring such as an earthquake or an anti-trust claim. The premium for additional limit can then be compared to the probability of the event to pinpoint when the purchase of additional insurance limit no longer provides a value to the System. The insurance team and brokers negotiate almost all of the policies directly to obtain the most favorable terms of coverage possible. Policies are also reviewed to ensure no coverage gaps – what is excluded in one policy must be covered by a different policy. Insurers must have an A rating or better from A.M. Best to be on the System program. Management meets with most of its underwriters at least once a year to obtain updates on any changes in business strategy or capacity. The System currently self-insures a portion of its professional and general liability. Such claims are paid through trust arrangements which are funded to a 75 percent confidence level based on projections from outside independent actuaries. The major lines of insurance renewed yearly include property, directors and officers, employment practices, auto, fiduciary, cyber/information security, workers' compensation, crime, and aviation.

Retirement Plans

As described more completely under the caption "Retirement Plans" in Note 6 to the combined audited financial statements included in EXHIBIT 7, the System currently sponsors defined benefit and contribution plans. Although the System had certain defined benefit plans in place prior to January 1, 2010, in April 2009, the PH&S Board of Directors approved a freeze of the two existing defined benefit plans, a cap on the ongoing cash balance interest credit formula and the implementation of new defined contribution plans referenced within Note 6, all effective December 31, 2009.

The System's remaining unfunded liability with respect to the defined benefit plans decreased from approximately 62 percent at December 31, 2017 to 58 percent at December 31, 2018. The decrease in the unfunded liability occurred primarily due to a change in the valuation discount rate and mortality table changes. The System's contribution to the defined benefit plans was approximately $99 million and $95 million at December 31, 2018 and 2017, respectively.

The System sponsors various defined contribution retirement plans that cover substantially all employees. The plans provide for employer matching contributions in an amount equal to a percentage of employee pretax contributions, up to a maximum amount. In addition, the System makes contributions to eligible employees based on years of service. Retirement expense related to these plans was $513 million and $478 million in December 31, 2018 and 2017, respectively, and is reflected in salaries and benefit expense in the accompanying combined statements of operations.

Compliance with California Seismic Standards

California's Hospital Seismic Safety Act (the "Seismic Safety Act") requires licensed acute care functions to be conducted only in facilities that meet specified seismic safety standards. The System has proactively worked towards seismic regulatory compliance for all of its California acute hospital facilities, as well as structural ("SPC") compliance and non-structural building systems bracing and anchorage ("NPC") compliance.

SJHS formally received seismic compliance extensions from the Office of Statewide Health Planning and Development ("OSHPD") via Senate Bill 90 for five hospital campuses with SPC1 buildings: St. Joseph Eureka; General Hospital, Eureka; and St. Jude Medical Center. The three campuses are in the process of completing the remaining required seismic compliance upgrades before January 2020. The total area of SJHS California acute care facilities is just under 3 million square feet. Of that total area, approximately 93 percent is already in seismic compliance with the extended January 2020 deadline, and that same area is approximately 56 percent seismically compliant with the 2030 deadline.

Relative to non-structural (building system bracing) compliance status, seven of the SJHS acute care facilities received exemption through January 2030 under Senate Bill 499, and three SJHS campuses are fully NPC compliant through January 2030, which leaves one remaining campus. This campus was granted an NPC 3 exemption until January 2020, and it is almost fully NPC compliant through January 2030 except for one area under construction, which will be completed by January 2020. Upon completion of work this hospital will then be NPC compliant through 2030. Hoag Hospital has also been actively achieving compliance with the Seismic Safety Act, 100 percent of the 1 million square feet Newport Beach campus are fully compliant with seismic standards of inpatient care to 2030. Seven buildings are currently classified as SPC-2, which would need to be either upgraded to SPC-4D or removed from providing acute-care services by 2030. In addition, there are 17 buildings at the campus that are currently classified as NPC-2. These would need to be upgraded and reclassified to NPC-5 by 2030 and meets the requirements of the Seismic Safety Act. The Irvine campus of Hoag Hospital has OSHPD approval for use as an acute care facility to 2030 and beyond from a structural (i.e. SPC) perspective. Both of the existing buildings at the Irvine campus of Hoag Hospital are currently classified as NPC-2 and would need to be upgraded and reclassified to NPC-5 by January 1, 2030.

Providence - Saint John's is seismically compliant to January 2030 and beyond. Providence Little Company of Mary Medical Center Torrance, Providence St. Joseph Medical Center and Providence Holy Cross Medical Center are seismically compliant until January 2030, and with additional work these three campuses would be compliant beyond 2030. Providence Tarzana Medical Center has three seismically noncompliant buildings which do not currently meet the seismic regulations; however, they received seismic compliance extensions through both January 2020 and October 2020 via SB 90 and AB 908, respectively.

The two Providence Little Company of Mary Medical Center San Pedro seismically noncompliant buildings were also granted extensions via SB 90. Construction on the Tarzana and San Pedro buildings began in 2017.

Finally, in light of the newly adopted Structural Performance Category 4D (SPC-4D) classification, the System is proactively evaluating several SPC2 buildings throughout its California hospital campuses for potential SPC-4D retrofit and re-classification for use beyond the January 2030 seismic compliance deadline. While it is too early to get definitive OSHPD review to determine the full impact, the retrofit and SPC-4D reclassification of those approved buildings will mitigate some of the longer term, January 2030 hospital replacement requirements and capital expenditures.

Community Benefit

Through programs and donations, health education, free care, medical research and more, our community benefit investments fulfill unmet needs in communities we serve across seven states.

Building on our commitment to care for those who are poor and vulnerable, we have invested $1.6 billion in community benefit in each of the past two years demonstrating our commitment to the communities we serve. In an environment of decreased reimbursement for government-sponsored medical care, community benefit spending related to the unpaid costs of Medicaid was $0.9 billion for the year ended December 31, 2018, compared with $1.0 billion for the same period in 2017.

Interest Rate Swap Arrangements

The System and/or certain of its affiliates enter into interest rate swap contracts from time to time to increase or decrease variable rate debt exposure, to achieve a targeted mix of fixed and floating rate indebtedness and for other purposes. At December 31, 2018, SJHS was party to seven interest rate swap agreements with a current notional amount totaling approximately $453 million and with varying expiration dates. The swap agreements require SJHS to make fixed rate payments in exchange for variable rate payments made by the counterparties. The market risk exposure of these agreements occurs when the fixed rate paid is greater than the variable rate received. At December 31, 2018, the total fair value of the combined interest rate swaps of approximately $84 million represents the estimated amount SJHS would have paid upon termination of these agreements as of that date. Fair values are based on independent valuations obtained and are determined by calculating the value of the discounted cash flows of the differences between the fixed interest rate of the interest rate swaps and the counterparty's forward London Interbank Offered Rate curve, which is the input used in the valuation, also taking into account any nonperformance risk. Changes in the fair value of the interest rate swaps are included within non-operating gains and losses. As of December 31, 2018, SJHS has no collateral requirement.

Litigation

Certain material litigation may result in an adverse outcome to the System. The System is involved in litigation and regulatory investigations arising in the course of doing business. After consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on the System's future consolidated financial position or results of operations.

A number of civil actions are pending or threatened against certain Affiliates, including Obligated Group Members, alleging medical malpractice. In the opinion of management of the System, based upon the advice of legal counsel and risk management personnel, the probable recoveries in these proceedings and the estimated costs and expenses of defense will be within applicable insurance limits or will not materially adversely affect the business or properties of the System.

Accreditation and Memberships

The System's acute care hospital facilities are appropriately licensed by applicable state licensing agencies, certified for Medicare and Medicaid/Medi-Cal reimbursement, and (except Covenant Levelland, Providence Seward Medical Center, Providence Valdez Medical Center and Swedish Issaquah) accredited by The Joint Commission. Each long-term care facility or unit is licensed by applicable state licensing agencies and is appropriately certified for Medicare and Medicaid/Medi-Cal reimbursement.

EXHIBIT 5
LIST OF BONDS TO WHICH REPORT RELATES

Alaska Industrial Development and Export Authority Revenue Bonds (Providence Health & Services) Series 2011A, issued in the original principal amount of $122,720,000;

California Health Facilities Financing Authority Revenue Bonds (St. Joseph Health System) Series 2009 A and B, issued in the original principal amount of $254,410,000;

California Health Facilities Financing Authority Revenue Bonds (Providence Health & Services) Series 2009B, issued in the original principal amount of $150,000,000;

California Health Facilities Financing Authority Variable Rate Refunding Revenue Bonds (St. Joseph Health System) Series 2009 C and D, issued in the original principal amount of $166,690,000;

California Heath Facilities Financing Authority Revenue Bonds (St. Joseph Health System) Series 2013 A, B, C, and D, issued in the original principal amount of $654,840,000;

California Health Facilities Financing Authority Revenue Bonds (Providence Health & Services) Series 2014A, issued in the original principal amount of $275,850,000;

California Health Facilities Financing Authority Revenue Bonds (Providence Health & Services) Series 2014B, issued in the original principal amount of $118,740,000;

California Health Facilities Financing Authority Revenue Bonds (Providence St. Joseph Health) Series 2016A, issued in the original principal amount of $448,165,000;

California Health Facilities Financing Authority Revenue Bonds (Providence St. Joseph Health) Series 2016B1, issued in the original principal amount of $95,240,000;

California Health Facilities Financing Authority Revenue Bonds (Providence St. Joseph Health) Series 2016B2, issued in the original principal amount of $95,245,000;

California Health Facilities Financing Authority Revenue Bonds (Providence St. Joseph Health) Series 2016B3, issued in the original principal amount of $95,245,000;

Lubbock Health Facilities Development Corporation Variable Rate Refunding Revenue Bonds (St. Joseph Health System), Series 2008B, issued in the original principal amount of $105,385,000;

Lubbock Health Facilities Development Corporation Revenue Bonds Direct Obligation Notes (Providence St. Joseph Health) Series 2016C, issued in the original principal amount of $39,215,000;

Montana Facility Finance Authority Direct Obligation Bonds (Providence St. Joseph Health) Series 2016F, issued in the original Principal amount of $50,810,000;

Oregon Facilities Authority Revenue Bonds (Providence Health & Services) Series 2011C, issued in the original principal amount of $22,355,000;

Oregon Facilities Authority Revenue Bonds (Providence Health & Services) Series 2013A, issued in the original principal amount of $78,190,000;

Oregon Facilities Authority Revenue Bonds (Providence Health & Services) Series 2015C, issued in the original principal amount of $71,070,000;

Washington Health Care Facilities Authority Revenue Bonds (Providence Health & Services) Series 2010A, issued in the original principal amount of $174,240,000;

Washington Health Care Facilities Authority Revenue Bonds (Providence Health & Services) Series 2011B, issued in the original principal amount of $91,170,000;

Washington Health Care Facilities Authority Revenue Bonds (Providence Health & Services) Series 2012A, issued in the original principal amount of $511,370,000;

Washington Health Care Facilities Authority Revenue Bonds (Providence Health & Services) Series 2012B, issued in the original principal amount of $100,000,000;

Washington Health Care Facilities Authority Revenue Bonds (Providence Health & Services) Series 2012C, issued in the original principal amount of $80,000,000;

Washington Health Care Facilities Authority Revenue Bonds (Providence Health & Services) Series 2012D, issued in the original principal amount of $80,000,000;

Washington Health Care Facilities Authority Revenue Bonds (Providence Health & Services) Series 2014C, issued in the original principal amount of $92,245,000;

Washington Health Care Facilities Authority Revenue Bonds (Providence Health & Services) Series 2014D, issued in the original principal amount of $178,770,000;

Washington Health Care Facilities Authority Revenue Bonds (Providence Health & Services) Series 2015A, issued in the original principal amount of $77,635,000;

Washington Health Care Facilities Authority Revenue Bonds Direct Obligation Notes (Providence St. Joseph Health) Series 2016D, issued in the original principal amount of $105,430,000;

Washington Health Care Facilities Authority Revenue Bonds Direct Obligation Notes (Providence St. Joseph Health) Series 2016E, issued in the original principal amount of $105,430,000;

Washington Health Care Facilities Authority Revenue Bonds (Providence St. Joseph Health) Series 2018B, issued in the original principal amount of $141,690,000;

Taxable Bonds Direct Obligation Notes (Providence Health & Services) Series 2005, issued in the original principal amount of $60,000,000;

Taxable Bonds Direct Obligation Notes (Providence Health & Services) Series 2009A, issued in the original principal amount of $250,000,000;

Taxable Bonds Direct Obligation Notes (Providence Health & Services) Series 2012E, issued in the original principal amount of $239,760,000;

Taxable Bonds Direct Obligation Notes (Providence Health & Services) Series 2013D, issued in the original principal amount of $252,285,000;

Taxable Bonds Direct Obligation Notes (Providence St. Joseph Health) Series 2016G, issued in the original principal amount of $100,000,000;

Taxable Bonds Direct Obligation Notes (Providence St. Joseph Health) Series 2016H, issued in the original principal amount of $300,000,000;

Taxable Bonds Direct Obligation Notes (Providence St. Joseph Health) Series 2016I, issued in the original principal amount of $400,000,000;

Taxable Bonds Direct Obligation Notes (Providence St. Joseph Health) Series 2018A, issued in the original principal amount of $350,000,000

EXHIBIT 6
OBLIGATED GROUP

A list of the System's acute care facilities in each region as of December 31, 2018, each of which is owned or operated by an Obligated Group Member, is provided in Exhibit 6.1 below.

EXHIBIT 6.1 - List of Acute Care Facilities by Region

Region	Obligated Group Member	Facility	Location(s)	Licensed Acute Care Beds*
Alaska				
	Providence Heath & Services-Washington	Providence Alaska Medical Center	Anchorage	401
		Providence Kodiak Island Medical Center(1)	Kodiak	25
		Providence Seward Medical and Care Center(1)	Seward	6
		Providence Valdez Medical Center(1)	Valdez	11
Swedish				
	Swedish Edmonds	Swedish Edmonds(2)	Edmonds	217
		Swedish Medical Center Campuses(3):		
	Swedish Health Services	Swedish Ballard	Ballard	133
		Swedish Issaquah	Issaquah	144
		Swedish Cherry Hill	Seattle	385
		Swedish First Hill	Seattle	697
Washington and Montana				
	Providence Heath & Services-Washington	Providence Centralia Hospital	Centralia	128
		Providence Regional Medical Center Everett	Everett	530
		Providence St. Peter Hospital(4)	Olympia	390
	Providence Heath & Services-Washington	Providence St. Joseph's Hospital	Chewelah	65
		Providence Mount Carmel Hospital	Colville	55
		Providence Sacred Heart Medical Center and Children's Hospital	Spokane	719
		Providence Holy Family Hospital	Spokane	197
		Providence St. Mary Medical Center	Walla Walla	142
	Kadlec Regional Medical Center	Kadlec Regional Medical Center	Richland	270
	Providence Heath & Services-Montana	St. Patrick Hospital	Missoula (MT)	253
	Providence St. Joseph Medical Center	Providence St. Joseph Medical Center	Polson (MT)	22
Oregon				
	Providence Heath & Services-Oregon	Providence Hood River Memorial Hospital	Hood River	25
		Providence Medford Medical Center	Medford	168
		Providence Milwaukie Hospital	Milwaukie	77
		Providence Newberg Medical Center	Newberg	40
		Providence Willamette Falls Medical Center	Oregon City	143
		Providence St. Vincent Medical Center	Portland	523
		Providence Portland Medical Center	Portland	483

Region	Obligated Group Member	Facility	Location(s)	Licensed Acute Care Beds*
		Providence Seaside Hospital(5)	Seaside	25
Northern California				
	St. Joseph Health Northern California, LLC.	St. Joseph Hospital	Eureka	153
		Redwood Memorial Hospital	Fortuna	35
		Queen of the Valley Medical Center	Napa	208
		Santa Rosa Memorial Hospital	Santa Rosa	298
Southern California				
	Providence Health System-Southern California	Providence St. Joseph Medical Center	Burbank	392
		Providence Holy Cross Medical Center	Mission Hills	329
		Providence Little Company of Mary Medical Center San Pedro	San Pedro	183
		Providence Tarzana Medical Center	Tarzana	246
		Providence Little Company of Mary Medical Center Torrance	Torrance	327
	Providence Saint John's Health Center	Providence Saint John's Health Center	Santa Monica	266
	St. Mary Medical Center	St. Mary Medical Center	Apple Valley	212
	St. Jude Medical Hospital, Inc.	St. Jude Medical Center	Fullerton	320
		Mission Hospital Regional Medical Center Campuses(6):		523
	Mission Hospital Regional Medical Center	Mission Hospital Regional Medical Center	Mission Viejo	
		Mission Hospital Laguna Beach	Laguna Beach	
		Hoag Memorial Hospital Presbyterian Campuses(7):		588
	Hoag Memorial Hospital Presbyterian	Hoag Memorial Hospital Presbyterian	Newport Beach	
		Hoag Hospital Irvine	Irvine	
	St. Joseph Hospital of Orange	St. Joseph Hospital of Orange(8)	Orange	463
Texas				
	Methodist Hospital Levelland	Covenant Hospital Levelland	Levelland	48
		CHS Campuses:		506
	Covenant Health System	Covenant Medical Center	Lubbock	
		Covenant Medical Center - Lakeside	Lubbock	
	Methodist Children's Hospital	Covenant Children's Hospital	Lubbock	269
	Methodist Hospital Plainview	Covenant Hospital Plainview	Plainview	68
TOTAL				**11,708**

** Includes all acute care licensure categories except for normal newborn bassinettes and partial hospitalization psychiatric beds*

(1) Leased and/or managed by Providence - Washington
(2) The legal entity Swedish Edmonds operates the hospital under a lease with Public Hospital District No. 2 of Snohomish County
(3) Four campuses with three licenses
(4) Includes a 50-bed chemical dependency center
(5) Leased to and managed by Providence - Oregon
(6) Two campuses on one license, including 36 acute care psychiatric beds in Laguna Beach
(7) Two campuses on one license
(8) Includes 37 acute care psychiatric beds

The System's principal owned or leased long-term care facilities as of December 31, 2018 is shown in Exhibit 6.2 is the table below.

EXHIBIT 6.2 - List of Long-Term Care Facilities by Region

Region	Obligated Group Member	Facility	Location(s)	Licensed Long-Term Care Beds
Facilities Owned or Leased By Obligated Group Members:				
Alaska				
	Providence Health & Services-Washington	Providence Kodiak Island Medical Center[1]	Kodiak	22
		Providence Seward Medical and Care Center[1]	Seward	40
		Providence Valdez Medical Center[1]	Valdez	10
		Providence Extended Care	Anchorage	96
		Providence Transitional Care Center	Anchorage	50
Washington and Montana				
	Providence Health & Services-Washington	Providence Marionwood	Issaquah	117
		Providence Mother Joseph Care Center	Olympia	152
		Providence Mount St. Vincent	Seattle	215
	Providence Health & Services-Washington	Providence St. Joseph Care Center	Spokane	162
Oregon				
	Providence Health & Services-Oregon	Providence Benedictine Nursing Center[2]	Mt. Angel	98
		Providence Child Center	Portland	58
Northern California				
	St. Joseph Health Northern California, LLC.	Santa Rosa Memorial Hospital	Santa Rosa	31
Southern California				
	Providence Health System-Southern California	Providence Holy Cross Medical Center	Mission Hills	48
		Providence Little Company of Mary Subacute Care Center San Pedro	San Pedro	125
		Providence Little Company of Mary Transitional Care Center	Torrance	115
		Providence St. Elizabeth Care Center	North Hollywood	52
Texas				
	Covenant Health System	Covenant Long-term Acute Care	Lubbock	56
TOTAL				**1,447**

(1) Leased and/or managed by Providence - Washington

(2) Also includes 15 adult foster care units

EXHIBIT 7
Providence St. Joseph Health
Supplementary Information and Audited Consolidated Financial Statements

Providence St. Joseph Health

EXHIBIT 7.1 - SUMMARY AUDITED COMBINED STATEMENTS OF OPERATIONS

	Ended December 31, 2018 (in 000's of dollars)		Ended December 31, 2017 (in 000's of dollars)	
	Consolidated	Obligated	Consolidated	Obligated
Operating Revenues:				
Net Service Revenues	$ 18,997,848	$ 18,327,589	$ 17,866,609	$ 17,387,036
Premium and Capitation Revenues	4,359,053	751,726	4,079,290	772,317
Other Operating Revenues	1,071,355	1,016,425	1,217,346	1,071,744
Net Operating Revenues	24,428,256	20,095,740	23,163,245	19,231,097
Operating Expenses:				
Salaries, Wages and Benefits	11,919,949	10,679,907	11,464,879	10,391,082
Supplies	3,562,637	3,311,462	3,389,917	3,194,180
Depreciation	1,082,443	1,009,534	1,037,984	974,623
Interest and Amortization	277,582	263,679	269,042	257,793
Other Expenses	7,420,104	4,064,273	6,998,330	3,826,726
Total Operating Expenses Before Restructuring Costs	24,262,715	19,328,855	23,160,152	18,644,404
Excess of Revenues Over Expenses from Operations				
Before Restructuring Costs	165,541	766,885	3,093	586,693
Restructuring Costs	162,146	162,146	-	-
Excess of Revenues Over Expenses from Operations	3,395	604,739	3,093	586,693
Net Non-operating (Losses) Gains	(447,788)	(422,537)	776,859	769,305
(Deficit) Excess of Revenues Over Expenses	$ (444,393)	$ 182,202	$ 779,952	$ 1,355,998

EXHIBIT 7.2 - SUMMARY AUDITED COMBINED STATEMENTS OF CASH FLOWS

	Ended December 31, 2018 (in 000's of dollars)		Ended December 31, 2017 (in 000's of dollars)	
	Consolidated	Obligated	Consolidated	Obligated
Net cash provided by operating activities	$ 1,348,012	$ 1,834,510	$ 1,268,066	$ 2,314,546
Net cash used in investing activities	(1,233,858)	(884,078)	(1,027,427)	(814,554)
Net cash provided by (used in) financing activities	112,054	(710,270)	130,363	(1,263,649)
Increase (decrease) in cash and cash equivalents	226,208	240,162	371,002	236,343
Cash and cash equivalents, beginning of period	1,371,189	786,926	1,000,187	550,583
Cash and cash equivalents, end of period	$ 1,597,397	$ 1,027,088	$ 1,371,189	$ 786,926

EXHIBIT 7.3 - SUMMARY AUDITED NET PATIENT REVENUE PAYOR MIX

	Ended December 31, 2018 (in 000's of dollars)		Ended December 31, 2017 (in 000's of dollars)	
	Consolidated	Obligated	Consolidated	Obligated
Commercial	49%	49%	50%	50%
Medicare	32%	32%	33%	33%
Medicaid	17%	16%	14%	15%
Self-pay and Other	2%	3%	3%	2%

EXHIBIT 7.4 - SUMMARY AUDITED COMBINED BALANCE SHEETS

	As of December 31, 2018 (in 000's of dollars)		As of December 31, 2017 (in 000's of dollars)	
	Consolidated	Obligated	Consolidated	Obligated
Current Assets:				
Cash and Cash Equivalents	$ 1,597,397	$ 1,027,088	$ 1,371,189	$ 786,926
Short-term Management Designated Investments	510,722	337,584	413,700	254,383
Accounts Receivable, Net	2,256,807	2,126,654	2,221,520	2,147,724
Other Current Assets	1,150,855	1,070,993	1,434,329	1,373,457
CP of Assets-Use is Limited	143,000	1,194	66,242	1,532
Total Current Assets	5,658,781	4,563,513	5,506,980	4,564,022
Assets Whose Use is Limited:				
Management Designated Cash and Investments	9,135,523	6,988,427	9,525,490	7,418,799
Other Restricted Assets	463,755	156,204	460,361	161,608
Assets Whose Use is Limited	9,599,278	7,144,631	9,985,851	7,580,407
Property Plant Equipment Net	10,870,578	10,286,917	10,955,120	10,495,562
Total Other Long-term Assets	1,300,183	1,932,833	1,196,723	1,732,368
Total Assets	$ 27,428,820	$ 23,927,894	$ 27,644,674	$ 24,372,359
Current Liabilities:				
Short-term Debt	$ 110,000	$ 110,000	$ 56,675	$ 56,675
Accounts Payable	1,097,689	983,562	684,382	623,661
Accrued Compensation	1,202,269	1,109,270	1,110,682	1,033,090
Other Current Liabilities	2,135,119	1,483,964	2,369,877	1,699,368
Total Current Liabilities	4,545,077	3,686,796	4,221,616	3,412,794
Long-Term Debt	6,257,868	6,125,953	6,484,528	6,457,366
Total Other Long-term Liabilities	2,234,915	1,549,115	2,193,453	1,562,861
Total Liabilities	13,037,860	11,361,864	12,899,597	11,433,021
Net Assets:				
Unrestricted	13,156,155	11,739,238	13,544,700	12,177,980
Restricted Net Assets	1,234,805	826,792	1,200,377	761,358
Total Net Assets	14,390,960	12,566,030	14,745,077	12,939,338
Total Liabilities and Net Assets	$ 27,428,820	$ 23,927,894	$ 27,644,674	$ 24,372,359

Providence St. Joseph Health

EXHIBIT 7.5 - KEY PERFORMANCE METRICS

	Ended December 31, 2018		Ended December 31, 2017	
	Consolidated	Obligated	Consolidated	Obligated
Total Acute Admissions	513,841	504,405	522,153	516,227
Total Acute Patient Days	2,441,202	2,395,267	2,420,196	2,391,407
Acute Outpatient Visits	12,481,103	11,796,227	12,353,677	11,759,499
Primary Care Visits	13,153,980	8,803,761	12,127,920	8,345,993
Inpatient Surgeries	223,367	217,394	226,149	221,487
Outpatient Surgeries	401,594	343,242	386,881	336,140
Long-Term Care Patient Days	413,477	401,861	398,917	387,459
Home Health Visits	1,280,207	850,032	1,166,858	793,982
Hospice Days	902,781	581,857	869,064	611,544
Housing and Assisted Living Days	622,805	247,419	612,698	248,169
Health Plan Members	648,331	n/a	647,781	n/a
Total Average Daily Census	6,688	6,562	6,631	6,552
Total Acute Licensed Beds	11,925	11,593	11,817	11,747
FTEs	105,114	93,584	103,058	93,326

EXHIBIT 7.6 - SUMMARY AUDITED COMBINING STATEMENTS OF OPERATIONS BY REGION

	Ended December 31, 2018 (in 000's of dollars)								
	Alaska	Swedish	Washington/ Montana	Oregon	Northern California	Southern California	West Texas/ Eastern New Mexico	Other/ Eliminations	Consolidated
Operating Revenues:									
Net Service Revenues	$ 850,931	$ 2,571,368	$ 4,375,585	$ 2,483,320	$ 1,387,912	$ 6,027,805	$ 996,516	$ 304,411	$ 18,997,848
Premium and Capitation Revenues	-	-	151,044	2,362,330	61,753	1,149,793	577,794	56,339	4,359,053
Other Operating Revenues	57,399	118,207	253,232	274,704	53,894	231,575	70,614	11,730	1,071,355
Net Operating Revenues	908,330	2,689,575	4,779,861	5,120,354	1,503,559	7,409,173	1,644,924	372,480	24,428,256
Operating Expenses:									
Salaries, Wages and Benefits	353,110	1,281,869	2,170,762	1,645,304	671,927	2,895,446	578,997	2,322,534	11,919,949
Supplies	114,235	444,274	779,090	498,446	202,245	1,021,449	227,910	274,988	3,562,637
Depreciation	47,438	107,746	138,421	118,223	53,766	285,011	52,562	279,276	1,082,443
Interest and Amortization	11,710	47,103	50,733	5,927	13,880	90,865	10,148	47,216	277,582
Other Expenses	276,759	870,538	1,673,067	2,694,962	494,973	3,037,892	732,070	(2,360,157)	7,420,104
Total Operating Expenses Before Restructuring Costs	803,252	2,751,530	4,812,073	4,962,862	1,436,791	7,330,663	1,601,687	563,857	24,262,715
Excess of Revenues Over Expenses from Operations Before Restructuring Costs	105,078	(61,955)	(32,212)	157,492	66,769	78,510	43,237	(191,377)	165,541
Restructuring Costs	-	-	-	-	-	-	-	162,146	162,146
Excess of Revenues Over Expenses from Operations	105,078	(61,955)	(32,212)	157,492	66,768	78,510	43,237	(353,523)	3,395
Net Non-operating (Losses) Gains	(25,987)	(20,671)	(46,384)	(63,763)	(18,399)	(88,790)	(3,406)	(180,388)	(447,788)
(Deficit) Excess of Revenues Over Expenses	$ 79,091	$ (82,626)	$ (78,596)	$ 93,729	$ 48,369	$ (10,280)	$ 39,831	$ (533,911)	$ (444,393)

EXHIBIT 7.7 - SUMMARY AUDITED COMBINING BALANCE SHEETS BY REGION

As of December 31, 2018
(in 000's of dollars)

	Alaska	Swedish	Washington/ Montana	Oregon	Northern California	Southern California	West Texas/ Eastern New Mexico	Other/ Eliminations	Consolidated
Current Assets:									
Cash and Cash Equivalents	$ 535,831	$ 133,624	$ 91,410	$ 612,595	$ 36,944	$ (504,844)	$ 234,332	$ 457,505	$ 1,597,397
Short-term Management Designated Investments	-	-	-	-	531	17,834	1,973	490,384	510,722
Accounts Receivable, Net	124,289	335,757	520,013	243,387	151,675	731,658	150,970	(942)	2,256,807
Other Current Assets	38,078	211,767	564,431	215,034	39,175	252,222	68,014	(237,866)	1,150,855
Current Portion of Assets-Use is Limited	-	-	-	-	-	-	-	143,000	143,000
Total Current Assets	698,198	681,148	1,175,854	1,071,016	228,325	496,870	455,289	852,081	5,658,781
Assets Whose Use is Limited:									
Management Designated Cash and Investments	668,389	490,822	827,429	1,971,123	419,599	2,762,486	157,366	1,838,309	9,135,523
Funds Held by Trustee, Gift Annuity, and Other	255	13,087	4,358	47,730	14,168	32,808	3,838	347,511	463,755
Assets Whose Use is Limited	668,644	503,909	831,787	2,018,853	433,767	2,795,294	161,204	2,185,820	9,599,278
Property Plant Equipment Net	458,157	1,274,677	1,655,197	1,067,294	665,354	3,852,140	526,212	1,371,547	10,870,578
Total Other Long-term Assets	48,187	113,256	211,027	33,517	12,851	529,727	77,658	273,960	1,300,183
Total Assets	$ 1,873,186	$ 2,572,990	$ 3,873,865	$ 4,190,680	$ 1,340,297	$ 7,674,031	$ 1,220,363	$ 4,683,408	$ 27,428,820
Current Liabilities:									
Short-term Debt	$ -	$ -	$ -	$ -	$ 1,605	$ 91,347	$ -	$ 17,048	$ 110,000
Accounts Payable	29,006	110,607	156,138	124,275	51,235	316,013	52,116	258,299	1,097,689
Accrued Compensation	33,551	97,794	180,807	131,748	47,634	295,683	53,513	361,539	1,202,269
Other Current Liabilities	28,369	138,448	362,179	464,559	72,278	455,217	175,241	438,828	2,135,119
Total Current Liabilities	90,926	346,849	699,124	720,582	172,752	1,158,260	280,870	1,075,714	4,545,077
Long-Term Debt	251,576	1,004,865	1,142,044	145,014	351,641	1,937,074	254,818	1,170,836	6,257,868
Total Other Long-term Liabilities	29,147	433,122	43,609	44,300	7,199	169,477	35,752	1,472,309	2,234,915
Total Liabilities	371,649	1,784,836	1,884,777	909,896	531,592	3,264,811	571,440	3,718,859	13,037,860
Net Assets:									
Unrestricted	1,483,569	690,169	1,933,406	3,077,807	749,715	3,725,032	610,977	885,480	13,156,155
Restricted Net Assets	17,968	97,985	55,682	202,977	58,990	684,188	37,946	79,069	1,234,805
Total Net Assets	1,501,537	788,154	1,989,088	3,280,784	808,705	4,409,220	648,923	964,549	14,390,960
Total Liabilities and Net Assets	$ 1,873,186	$ 2,572,990	$ 3,873,865	$ 4,190,680	$ 1,340,297	$ 7,674,031	$ 1,220,363	$ 4,683,408	$ 27,428,820

EXHIBIT 7.8 - KEY PERFORMANCE METRICS BY REGION

As of December 31, 2018

	Alaska	Swedish	Washington/ Montana	Oregon	Northern California	Southern California	West Texas/ Eastern New Mexico	Consolidated
Total Acute Admissions	16,558	64,803	127,367	62,148	29,442	187,465	26,058	513,841
Total Acute Patient Days	116,970	300,338	655,828	302,230	152,985	779,489	133,362	2,441,202
Acute Outpatient Visits	459,472	752,768	3,011,605	3,416,006	741,117	3,550,226	549,910	12,481,103
Primary Care Visits	137,129	1,922,747	4,053,384	2,420,400	498,088	3,568,745	553,487	13,153,980
Inpatient Surgeries	8,673	30,565	59,414	30,045	8,329	77,298	9,043	223,367
Outpatient Surgeries	12,518	52,879	115,728	63,492	17,513	115,193	24,271	401,594
Long-Term Care Patient Days	59,615	n/a	12,305	45,369	n/a	85,229	11,616	413,477
Home Health Visits	13,530	n/a	32,516	308,935	54,621	451,126	n/a	1,280,207
Hospice Days	23,594	n/a	n/a	187,370	36,002	132,372	58,391	902,781
Housing and Assisted Living Days	29,191	n/a	27,065	144,121	n/a	n/a	n/a	622,805
Health Plan Members	n/a	n/a	n/a	648,331	n/a	n/a	n/a	648,331
Total Average Daily Census	320	823	1,797	828	419	2,136	365	6,688
Total Acute Licensed Beds	485	1,576	2,743	1,484	774	3,849	1,014	11,925
FTEs	3,862	10,897	21,280	16,482	5,041	27,266	6,086	105,114

PROVIDENCE ST. JOSEPH HEALTH

Combined Financial Statements

December 31, 2018 and 2017

(With Independent Auditors' Report Thereon)

KPMG LLP
Suite 2900
1918 Eighth Avenue
Seattle, WA 98101

Independent Auditors' Report

The Board of Directors
Providence St. Joseph Health:

We have audited the accompanying combined financial statements of Providence St. Joseph Health, which comprise the combined balance sheets as of December 31, 2018 and 2017, and the related combined statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the combined financial statements.

Management's Responsibility for the Financial Statements

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

Auditors' Responsibility

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

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

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

Opinion

In our opinion, the combined financial statements referred to above present fairly, in all material respects, the financial position of Providence St. Joseph Health as of December 31, 2018 and 2017, and the results of its operations and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

KPMG LLP is a Delaware limited liability partnership and the U.S. member
firm of the KPMG network of independent member firms affiliated with
KPMG International Cooperative ("KPMG International"), a Swiss entity.

Emphasis of Matter

As discussed in Note 1 to the combined financial statements, in 2018, Providence St. Joseph Health adopted new accounting guidance in Accounting Standards Update (ASU) No. 2014-09, *Revenue from Contracts with Customers* (Topic 606) and ASU No. 2016-14, *Presentation of Financial Statements of Not-for-Profit Entities (Topic 958).* Our opinion is not modified with respect to this matter.

Other Matter

Our audit was conducted for the purpose of forming an opinion on the combined financial statements as a whole. The Obligated Group Combining Balance Sheets and Statements of Operations Information included on pages 34 and 35 is presented for purposes of additional analysis and is not a required part of the combined financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the combined financial statements. The information has been subjected to the auditing procedures applied in the audit of the combined financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the combined financial statements or to the combined financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the combined financial statements as a whole.

KPMG LLP

Seattle, Washington
March 14, 2019

PROVIDENCE ST. JOSEPH HEALTH

Combined Balance Sheets

December 31, 2018 and 2017

(In millions of dollars)

Assets		**2018**	**2017**
Current assets:			
Cash and cash equivalents	$	1,597	1,371
Accounts receivable, less allowance for bad debts of $119 and $227, respectively		2,257	2,222
Supplies inventory		293	277
Other current assets		858	1,157
Current portion of assets whose use is limited		654	480
Total current assets		5,659	5,507
Assets whose use is limited		9,599	9,986
Property, plant, and equipment, net		10,871	10,955
Other assets		1,300	1,197
Total assets	$	27,429	27,645
Liabilities and Net Assets			
Current liabilities:			
Current portion of long-term debt	$	300	78
Master trust debt classified as short-term		110	57
Accounts payable		1,098	684
Accrued compensation		1,202	1,111
Other current liabilities		1,835	2,291
Total current liabilities		4,545	4,221
Long-term debt, net of current portion		6,258	6,485
Pension benefit obligation		1,065	1,054
Other liabilities		1,170	1,139
Total liabilities		13,038	12,899
Net assets:			
Controlling interests		12,988	13,366
Noncontrolling interests		168	179
Net assets without donor restrictions		13,156	13,545
Net assets with donor restrictions		1,235	1,201
Total net assets		14,391	14,746
Total liabilities and net assets	$	27,429	27,645

See accompanying notes to combined financial statements.

PROVIDENCE ST. JOSEPH HEALTH

Combined Statements of Operations

Years ended December 31, 2018 and 2017

(In millions of dollars)

		2018	2017
Operating revenues:			
Net patient service revenues	$	19,109	18,136
Provision for bad debts		(111)	(269)
Net patient service revenues less provision for bad debts		18,998	17,867
Premium revenues		2,981	2,745
Capitation revenues		1,378	1,334
Other revenues		1,071	1,217
Total operating revenues		24,428	23,163
Operating expenses:			
Salaries and benefits		11,883	11,464
Supplies		3,563	3,390
Purchased healthcare services		2,414	2,539
Interest, depreciation, and amortization		1,360	1,307
Purchased services, professional fees, and other		5,043	4,460
Total operating expenses before restructuring costs		24,263	23,160
Excess of revenue over expenses from operations before restructuring costs		165	3
Restructuring costs		162	—
Excess of revenue over expenses from operations		3	3
Net nonoperating (losses) gains:			
Loss on extinguishment of debt		(6)	—
Investment (loss) income, net		(366)	882
Other		(76)	(105)
Total net nonoperating (losses) gains		(448)	777
(Deficit) excess of revenues over expenses	$	(445)	780

See accompanying notes to combined financial statements.

PROVIDENCE ST. JOSEPH HEALTH

Combined Statements of Changes in Net Assets

Years ended December 31, 2018 and 2017

(In millions of dollars)

	Without donor restrictions			
	Controlling interests	Noncontrolling interests	With donor restrictions	Total net assets
Balance, December 31, 2016	$ 12,560	200	1,036	13,796
Excess of revenues over expenses	747	33	—	780
Contributions, grants, and other	(43)	(54)	245	148
Net assets released from restriction	44	—	(80)	(36)
Pension related changes	58	—	—	58
Increase (decrease) in net assets	806	(21)	165	950
Balance, December 31, 2017	13,366	179	1,201	14,746
(Deficit) excess of expenses over revenues	(469)	24	—	(445)
Contributions, grants, and other	85	(35)	145	195
Net assets released from restriction	35	—	(111)	(76)
Pension related changes	(29)	—	—	(29)
(Decrease) increase in net assets	(378)	(11)	34	(355)
Balance, December 31, 2018	$ 12,988	168	1,235	14,391

See accompanying notes to combined financial statements.

PROVIDENCE ST. JOSEPH HEALTH

Combined Statements of Cash Flows

Years ended December 31, 2018 and 2017

(In millions of dollars)

		2018	2017
Cash flows from operating activities:			
(Decrease) increase in net assets	$	(355)	950
Adjustments to reconcile (decrease) increase in net assets to net cash provided by operating activities:			
Gain on divestiture		—	(133)
Depreciation and amortization		1,083	1,057
Provision for bad debt		111	269
Loss on extinguishment of debt		6	—
Restricted contributions and investment income received		(145)	(245)
Net realized and unrealized losses (gains) on investments		487	(761)
Changes in certain current assets and current liabilities		176	166
Change in certain long-term assets and liabilities		(15)	(35)
Net cash provided by operating activities		1,348	1,268
Cash flows from investing activities:			
Property, plant, and equipment additions, net of disposals		(857)	(1,009)
(Purchases) sales of securities, net		(71)	18
Purchases of alternative investments and commingled funds		(679)	(551)
Proceeds from sales of alternative investments and commingled funds		415	367
Cash acquired through affiliation and divestiture activities, net of cash paid		6	114
Other investing activities		(48)	34
Net cash used in investing activities		(1,234)	(1,027)
Cash flows from financing activities:			
Proceeds from restricted contributions and restricted income		145	245
Debt borrowings		566	376
Debt payments		(608)	(483)
Other financing activities		9	(8)
Net cash provided by financing activities		112	130
Increase in cash and cash equivalents		226	371
Cash and cash equivalents, beginning of year		1,371	1,000
Cash and cash equivalents, end of year	$	1,597	1,371
Supplemental disclosure of cash flow information:			
Cash paid for interest, net of amounts capitalized	$	277	245

See accompanying notes to combined financial statements.

(1) Basis of Presentation and Significant Accounting Policies

(a) Reporting Entity

Providence St. Joseph Health (the Health System), a Washington nonprofit corporation, is the sole corporate member of Providence Health & Services (PHS) and the St. Joseph Health System (SJHS). PHS, a Washington nonprofit corporation, is a Catholic healthcare system sponsored by the public juridic person, Providence Ministries. SJHS, a California nonprofit public benefit corporation, is a Catholic healthcare system sponsored by the public juridic person, St. Joseph Health Ministry.

The Health System seeks to improve the health of the communities it serves, especially the poor and vulnerable. The Health System operations include 51 hospitals and a comprehensive range of services provided across Alaska, California, Montana, New Mexico, Oregon, Texas, and Washington. The Health System also provides population health management through various affiliated licensed insurers and other risk-bearing entities.

The Health System has been recognized as exempt from federal income taxes, except on unrelated business income, under Section 501(a) of the Internal Revenue Code (IRC) as an organization described in Section 501(c)(3) and further described as a public charitable organization under Section 509(a)(3). PHS, SJHS, and substantially all of the various corporations within the Health System have been granted exemptions from federal income tax under Section 501(a) of the Internal Revenue Code as charitable organizations described in Section 501(c)(3). During 2018 and 2017, the Health System did not record any liability for unrecognized tax benefits.

The accompanying combined balance sheets and related combined statements of operations, changes in net assets, and cash flows reflect the Health System's financial position and results of operations as of and for the years ended December 31, 2018 and 2017.

(b) Basis of Presentation

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

(c) Performance Indicator

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

(d) Operating and Nonoperating Activities

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

(e) Restructuring Costs

Restructuring costs were recorded during the year ended December 31, 2018. The amount was comprised of asset impairment, severance, and consulting expenses related to restructuring initiatives.

(f) Use of Estimates and Assumptions

The preparation of the combined financial statements in conformity with U.S. generally accepted accounting principles requires the use of estimates and assumptions that affect the reported amounts of assets and liabilities and the reported amounts of revenues and expenses during the reporting periods. Significant estimates and assumptions are used for, but not limited to: (1) allowance for contractual revenue adjustments; (2) allowance for bad debts; (3) fair value of acquired assets and assumed liabilities in business combinations; (4) fair value of investments; (5) reserves for self-insured healthcare plans; and (6) reserves for professional, workers' compensation and general insurance liability risks.

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

(g) Cash and Cash Equivalents

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

(h) Supplies Inventory

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

(i) Property, Plant, and Equipment

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

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

Property, plant, and equipment and the total accumulated depreciation are as follows as of December 31:

	Approximate useful life (years)	2018	2017
Land	—	$ 1,459	1,465
Buildings and improvements	5–60	10,036	9,714
Equipment:			
Fixed	5–25	1,289	1,278
Major movable and minor	3–20	6,050	5,833
Construction in progress	—	970	1,030
		19,804	19,320
Less accumulated depreciation		(8,933)	(8,365)
Property, plant, and equipment, net		$ 10,871	10,955

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

(Continued)

(j) Other Assets

Other assets are summarized as follows as of December 31:

		2018	2017
Investment in nonconsolidated joint ventures	$	337	315
Intangible assets		236	248
Goodwill		229	190
Beneficial interest in noncontrolled foundations		176	160
Other		322	284
Total other assets	$	1,300	1,197

Goodwill is recorded as the excess of cost over fair value of the acquired net assets. Indefinite-lived intangible assets are recorded at fair value using various methods depending on the nature of the intangible asset. Both goodwill and indefinite-lived intangible assets are tested annually for impairment. Definite-lived intangible assets are amortized using the straight-line method over the estimated useful lives of the assets.

The Health System recorded no goodwill impairment for the year ended December 31, 2018 and $14 during the year ended December 31, 2017.

(k) Investments Including Assets Whose Use Is Limited

The Health System has classified all of its investments as trading securities. These investments are reported on the combined balance sheets at fair value on a trade-date basis.

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

(l) Liquidity

Cash and cash equivalents and accounts receivable are the primary liquid resources used by the Health System to meet expected expenditure needs within the next year. The Health System has credit facility programs, as described in Note 5, available to meet unanticipated liquidity needs. Although intended to satisfy long-term obligations, management estimates that approximately 68% of noncurrent investments, as stated at December 31, 2018, could be utilized within the next year if needed.

(m) Derivative Instruments

The Health System allows certain investment managers to use derivative financial instruments (futures and forward currency contracts) to manage interest rate risk related to the Health System's fixed-income holdings. Also, the Health System uses derivative financial instruments (interest rate swaps) to manage its interest rate exposure and overall cost of borrowing. The interest rate swap agreements do not meet the criteria for hedge accounting and all changes in the valuation are recognized as a component of net nonoperating (losses) gains in the accompanying combined statements of operations.

(n) Net Assets

Net assets without donor restrictions are those that are not subject to donor-imposed stipulations. Amounts related to the Health System's noncontrolling interests in certain joint ventures are included in net assets without donor restrictions.

Net assets with donor restrictions are those whose use by the Health System has been limited by donors to a specific time period, in perpetuity, and/or purpose.

Net assets with donor restrictions are available for the following purposes as of December 31:

		2018	2017
Program support	$	903	821
Capital acquisition		211	197
Low-income housing and other		121	183
Total net assets with donor restrictions	$	1,235	1,201

(o) Donor-Restricted Gifts

Unconditional promises to give cash and other assets to the Health System are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the promise to give is no longer conditional. The gifts are reported as contributions with donor restrictions if they are received with donor stipulations that limit the use of the donated assets. When the terms of a donor restriction are met, net assets with donor restrictions are reclassified as net assets without donor restrictions and reported as other operating revenues in the combined statements of operations or as net assets released from restriction in the combined statements of changes in net assets.

(p) Charity Care and Community Benefit

The Health System provides community benefit activities that address significant health priorities within its geographic service areas. These activities include Medicaid and Medicare shortfalls, community health services, education and research, and free and low-cost care (charity care).

(Continued)

Charity care is reported at cost and is determined by multiplying the charges incurred at established rates for services rendered by the Health System's cost-to-charge ratio. The cost of charity care provided by the Health System for the years ended December 31, 2018 and 2017 was $303 and $259, respectively.

(q) Subsequent Events

The Health System has performed an evaluation of subsequent events through March 14, 2019, the date the accompanying combined financial statements were issued.

(r) New Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2014-09, *Revenue from Contracts with Customers (Topic 606)*. The ASU replaces most existing revenue recognition guidance. The ASU was adopted on January 1, 2018 using the cumulative effect method for those contracts that were not substantially completed as of January 1, 2018. Results for reporting periods beginning on or after January 1, 2018 are presented under Topic 606, while prior period amounts continue to be presented in accordance with the Health System's historical accounting under *Revenue Recognition (Topic 605)*. The adoption of the ASU primarily changed the Health System's presentation of revenues and the provision and allowance for bad debts. The ASU requires revenue to be recognized based on the Health System's estimate of the transaction price the Health System expects to collect as a result of satisfying its performance obligations. Accordingly, for performance obligations satisfied after January 1, 2018, the Health System no longer separately presents a provision for bad debts on the combined statements of operations or the related allowance for bad debts on the combined balance sheets. However, as a result of the Health System's election to apply the ASU only to contracts not substantially completed as of January 1, 2018, the Health System continues to maintain an allowance for bad debts related to performance obligations satisfied prior to January 1, 2018. Changes to the allowance for bad debts, other than the write-offs of uncollectable accounts, are recorded through the provision for bad debts on the combined statements of operations in accordance with Topic 605. The adoption of Topic 606 did not have a significant impact on the recognition of net patient services revenues for any periods prior to adoption. Management also expects the impact of this new standard in future periods will not be significant.

In January 2016, the FASB issued ASU 2016-01, *Financial Instruments – Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities*, which updates certain aspects of recognition, measurement, presentation and disclosure of financial instruments. The Health System implemented ASU 2016-01 for the fiscal year beginning January 1, 2018. The provisions of the standard did not have a material impact on the combined financial statements.

In February 2016, the FASB issued ASU 2016-02, *Leases (Topic 842)*, which requires lessees to recognize a lease liability and a right of use asset for all lease obligations with exception to short-term leases. The lease liability will represent the lessee's obligation to make lease payments arising from the lease measured on a discounted basis and the right of use asset will represent the lessee's right to use or control the use of a specified asset for a lease term. The lease guidance also simplifies accounting for sale-leaseback transactions. Topic 842 is effective for the Health System beginning on January 1, 2019. In 2018, the FASB updated its guidance allowing entities to adopt the provisions of the standard prospectively without adjusting comparative periods. The Health System is planning to elect this option. Management expects to record right-of-use assets and lease liabilities of approximately $1.4 billion and $1.6 billion, respectively, on its combined balance sheets. The adoption of Topic 842 is not expected to have a significant impact on the results of operations or cash flows. The Health System will include new disclosures in 2019 in accordance with Topic 842.

In August 2016, the FASB issued ASU 2016-14, *Presentation of Financial Statements of Not-for-Profit Entities*, with the intent of reducing diversity in reporting practice, reduce complexity, and enhance understandability of not-for-profit (NFP) financial statements. This ASU contains the following key aspects; (A) reduces the number of net asset classes presented from three to two: with donor restrictions and without donor restrictions; (B) requires all NFPs to present expenses by their functional and their natural classifications in one location in the financial statements; (C) requires NFPs to provide quantitative and qualitative information about management of liquid resources and availability of financial assets to meet cash needs within one year of the balance sheet date; and (D) retains the options to present operating cash flows in the statement of cash flows using either the direct or indirect method. The Health System implemented ASU 2016-14 as of January 1, 2018.

The impact of adoption resulted in enhanced disclosures about the classification of expenses and management of liquid resources. As a result of adoption, temporarily restricted and permanently restricted net asset in the amounts $958 and $243, respectively, were combined to create net assets with donor restrictions as stated on the combined balance sheets as of December 31, 2017.

In March 2017, the FASB issued (ASU) 2017-07, *Compensation – Retirement Benefits (Topic 715): Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost*. The Health System adopted the ASU for the period beginning January 1, 2017, and $38 in net periodic benefit costs were recorded in net nonoperating (losses) gains on the statements of operations for the period ended December 31, 2017.

(s) Reclassifications

Certain reclassifications, which have no impact on net assets or changes in net assets, have been made to prior year amounts to conform to the current year presentation.

(2) Affiliation Activities and Divestitures

Effective February 23, 2017 the Health System and Catholic Health Initiatives entered into an agreement with Laboratory Corporation of America to sell all of its ownership interest in Pathology Associates Medical Laboratories (PAML) and its affiliated joint ventures. PAML was a PHS consolidated joint venture. A gain in the amount of $133 was recorded in other operating revenues on the combined statements of operations

during the year ended December 31, 2017. There were no significant affiliation activities for the years ended December 31, 2018 and 2017.

(3) Revenue Recognition

(a) Net Patient Service Revenues

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

Net patient service revenues are recognized at the time services are provided to patients. Revenue is recorded in the amount which the Health System expects to collect, which may include variable components. Variable consideration is included in the transaction price to the extent that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the variable consideration is subsequently resolved. Adjustments from finalization of prior years' cost reports and other third-party settlement estimates resulted in an increase in net patient service revenues of $6 and $27 for the years ended December 31, 2018 and 2017, respectively.

Various states in which the Health System operates have instituted a provider tax on certain patient service revenues at qualifying hospitals to increase funding from other sources and obtain additional Federal funds to support increased payments to providers of Medicaid services. The taxes are included in purchased services, professional fees, and other expenses in the accompanying combined statements of operations and were $591 and $434 for the years ended December 31, 2018 and 2017, respectively. These programs resulted in enhanced payments from these states in the way of lump-sum payments and per claim increases. These enhanced payments are included in net patient service revenues in the accompanying combined statements of operations and were $894 and $471 for the years ended December 31, 2018 and 2017, respectively.

(b) Premium and Capitation Revenues

Premium and capitation revenues are received on a prepaid basis and are recognized as revenue ratably over the period for which the enrolled member is entitled to healthcare services. The timing of the Health System's performance may differ from the timing of the payment received, which may result in the recognition of a contract asset or a contract liability. The balance of contract liabilities was $24 as of January 1, 2018 and was recognized as revenue in the combined statements of operations during 2018. The balance of contract liabilities was $29 as of December 31, 2018. The Health System has no material contract assets.

(c) Allowance for Bad Debts

As a result of adopting ASU 2014-09 as described in Note 1, the Health System continues to maintain an allowance for bad debts related to performance obligations satisfied prior to January 1, 2018.

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

The estimates made and changes affecting those estimates are summarized as follows for the years ended December 31:

		2018	2017
Changes in allowance for bad debts:			
Allowance for doubtful accounts at beginning of year	$	227	271
Write-off of uncollectible accounts, net of recoveries		(219)	(313)
Provision for bad debts		111	269
Allowance for bad debts at end of year	$	119	227

(d) Disaggregation of Revenue

The Health System earns the majority of its revenues from contracts with customers. Revenues and adjustments not related to contracts with customers are included in other revenue.

(Continued)

Operating revenues from contracts with customers by state are as follows for the years ended December 31:

		2018	2017
Alaska	$	851	818
Washington		6,724	6,550
Montana		433	415
Oregon		5,091	4,791
California		8,684	7,966
Texas		1,574	1,406
Total revenues from contracts with customers		23,357	21,946
Other revenues		1,071	1,217
Total operating revenues	$	24,428	23,163

Operating revenues from contracts with customers by line of business are as follows for the years ended December 31:

		2018	2017
Hospitals	$	16,187	15,344
Health plans and accountable care		3,212	2,993
Physician and outpatient activities		2,726	2,451
Long-term care, home care, and hospice		990	845
Other		242	313
Total revenues from contracts with customers		23,357	21,946
Other revenues		1,071	1,217
Total operating revenues	$	24,428	23,163

Operating revenues from contracts with customers by payor are as follows for the years ended December 31:

		2018	2017
Commercial	$	11,503	11,041
Medicare		7,540	7,311
Medicaid		3,781	3,041
Self-pay and other		533	553
Total revenues from contracts with customers		23,357	21,946
Other revenues		1,071	1,217
Total operating revenues	$	24,428	23,163

(4) Fair Value Measurements

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

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

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

(a) Assets Whose Use Is Limited

The fair value of assets whose use is limited, other than those investments measured using net asset value per share (NAV) as a practical expedient for fair value, is estimated using quoted market prices or other observable inputs when quoted market prices are unavailable.

The composition of assets whose use is limited is set forth in the following tables:

	December 31, 2018	Fair value measurements at reporting date using Level 1	Level 2	Level 3
Management-designated cash and investments:				
Cash and cash equivalents	$ 308	308	—	—
Equity securities:				
Domestic	1,012	1,012	—	—
Foreign	317	317	—	—
Mutual funds	1,214	1,214	—	—
Domestic debt securities:				
State and federal government	1,607	951	656	—
Corporate	756	—	756	—
Other	507	—	507	—
Foreign debt securities	186	—	186	—
Commingled funds	336	336	—	—
Other	17	—	17	—
Investments measured using NAV	3,386	—	—	—
Total management-designated cash and investments	9,646			
Gift annuities, trusts, and other	184	53	12	119
Funds held by trustee:				
Cash and cash equivalents	112	112	—	—
Domestic debt securities	274	151	123	
Foreign debt securities	37	—	37	—
Total funds held by trustee	423			
Total assets whose use is limited	$ 10,253			

	December 31, 2017	Fair value measurements at reporting date using		
		Level 1	Level 2	Level 3
Management-designated cash and investments:				
Cash and cash equivalents	$ 547	547	—	—
Equity securities:				
Domestic	1,058	1,058	—	—
Foreign	372	372	—	—
Mutual funds	1,313	1,313	—	—
Domestic debt securities:				
State and federal government	1,441	961	480	—
Corporate	717	—	717	—
Other	460	—	460	—
Foreign debt securities	155	—	155	—
Commingled funds	545	545	—	—
Other	20	—	20	—
Investments measured using NAV	3,312	—	—	—
Total management-designated cash and investments	9,940			
Gift annuities, trusts, and other	181	41	35	105
Funds held by trustee:				
Cash and cash equivalents	105	105	—	—
Domestic debt securities	216	113	103	—
Foreign debt securities	24	—	24	—
Total funds held by trustee	345			
Total assets whose use is limited	$ 10,466			

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

The following table presents information, including unfunded commitments for investments where the NAV was used to estimate the value of the investments as of December 31:

	Fair value		Unfunded	Redemption	Redemption
	2018	2017	commitments	frequency	notice period
Hedge funds:					
Long/short equity	$ 639	579	—	Monthly, quarterly, semi-annually, or annually	30–120 days
Credit	360	300	—	Quarterly or annually	45–150 days
Relative value	208	206	—	Quarterly	60–90 days
Global macros	244	278	—	Monthly or quarterly	2–90 days
Fund of hedge funds	7	82	—	Quarterly	90 days
Private equity	372	258	566	Not applicable	Not applicable
Private real estate	155	75	240	Not applicable	Not applicable
Risk parity	84	110	—	Monthly or annually	5–60 days
Real assets	244	315	56	Monthly or quarterly	10–60 days
Commingled	1,073	1,109	—	Monthly, quarterly, or semi-annually	6–90 days
Total	$ 3,386	3,312	862		

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

Hedge funds are portfolios of investments that use advanced investment strategies, such as long/short equity, credit, relative value, global macro, and fund of hedge funds positions in both domestic and international markets, with the goal of diversifying portfolio risk and generating return. The Health System's investments in hedge funds include certain funds with provisions that limit the Health System's ability to access assets invested. These provisions include lockup terms that range up to three years from the subscription date or are continuous and determined as a percent of total assets invested. The Health System is in various stages of the lockup periods dependent on hedge fund and period of initial investments.

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

Risk parity is an approach to investment portfolio management which focuses on allocation of risk, usually defined as volatility, rather than allocation of capital. The risk parity approach asserts that when asset allocations are adjusted to the same risk level, the risk parity portfolio can achieve a higher Sharpe ratio and can be more resistant to market downturns than the traditional portfolio. The key to risk parity is to diversify across asset classes that behave differently across economic environments.

Real asset strategies invest in securities backed by tangible real assets, with the objective of achieving attractive diversified total returns over the long term, while maximizing the potential for real returns in periods of rising inflation. Real asset investments should provide a return in excess of inflation, and their performance should be sensitive to changes in inflation or expectations for future levels of inflation. The real asset category is made up of many different underlying sectors inclusive of agriculture, commodities, gold, infrastructure, private energy, MLPs (Master Limited Partnerships), real estate, REITs (Real Estate Investment Trusts), timberland, and TIPS (Treasury Inflation Protected Securities). Each of these sectors tends to have a high degree of sensitivity to inflation and be less correlated with traditional equities and fixed income.

Commingled describes a type of fund structure. Commingled funds consist of assets from several accounts that are blended together. Investors in commingled fund investments benefit from economies of scale, which allow for lower trading costs per dollar of investment.

(b) Unsettled transactions

Investment sales and purchases initiated prior to and settled subsequent to the combined balance sheet date result in amounts due from and to brokers. As of December 31, 2018, the Health System recorded a receivable of $102 for investments sold but not settled and a payable of $305 for investments purchased but not settled in other current assets and other current liabilities, respectively, in the accompanying combined balance sheets. As of December 31, 2017, the Health System recorded a receivable of $174 for investments sold but not settled and a payable of $428 for investments purchased but not settled in other current assets and other current liabilities, respectively, in the accompanying combined balance sheets.

(c) Derivative Instruments

The investment managers have executed master netting arrangements with the counterparties of the futures and forward currency purchase and sale contracts whereby the financial instruments held by the same counterparty are legally offset as the instruments are settled. The following table presents gross investment derivative assets and liabilities reported on a net basis at fair value included in assets whose use is limited in the combined balance sheets as of December 31:

		2018	2017
Derivative assets:			
Futures contracts	$	707	275
Foreign currency forwards and other contracts		153	86
Total derivative assets	$	860	361
Derivative liabilities:			
Futures contracts	$	(707)	(275)
Foreign currency forwards and other contracts		(153)	(84)
Total derivative liabilities	$	(860)	(359)

(Continued)

(d) Investment (Loss) Income, Net

		2018	2017
Interest and dividend income	$	121	121
Net realized gains on sale of trading securities		165	166
Change in net unrealized (losses) gains on trading securities		(652)	595
Investment (loss) income, net	$	(366)	882

(e) Assets Measured Using Significant Unobservable Inputs

The following table presents the Health System's activity for assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) as defined in Topic 820:

Balance at December 31, 2016	$	88
Total realized and unrealized losses, net		(2)
Total purchases		21
Total sales		(2)
Balance at December 31, 2017		105
Total realized and unrealized gains, net		3
Total purchases		16
Total sales		(5)
Balance at December 31, 2018	$	119

There were no significant transfers between assets classified as Level 1 and Level 2 during the years ended December 31, 2018 and 2017.

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

(5) Debt

(a) Short-Term and Long-Term Debt

The Health System has borrowed master trust debt issued through the following:

- California Health Facilities Financing Authority (CHFFA)
- Alaska Industrial Development and Export Authority (AIDEA)
- Washington Health Care Facilities Authority (WHCFA)

- Montana Facility Finance Authority (MFFA)
- Lubbock Health Facilities Development Corp (LHFDC)
- Oregon Facilities Authority (OFA)

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

	Maturing through	Coupon rates	Unpaid principal 2018	Unpaid principal 2017
Master trust debt:				
Fixed rate:				
Series 2005, Direct Obligation Notes	2030	5.30–5.39%	$ 38	40
Series 2006C, WHCFA Revenue Bonds	2033	5.25	—	69
Series 2006D, WHCFA Revenue Bonds	2033	5.25	—	69
Series 2006E, WHCFA Revenue Bonds	2033	5.25	—	26
Series 2008B, LHFDC Revenue Bonds	2023	4.00–5.00	24	33
Series 2008C, CHFFA Revenue Bonds	2038	3.00–6.50	—	6
Series 2009A, Direct Obligation Notes	2019	6.25	100	100
Series 2009A, CHFFA Revenue Bonds	2039	5.50–5.75	185	185
Series 2009B, CHFFA Revenue Bonds	2039	5.50	150	150
Series 2009B, CHFFA Revenue Bonds	2021	5.25	26	37
Series 2009C, CHFFA Revenue Bonds	2034	5.00	91	91
Series 2009D, CHFFA Revenue Bonds	2034	1.70	40	40
Series 2010A, WHCFA Revenue Bonds	2039	4.88–5.25	174	174
Series 2011A, AIDEA Revenue Bonds	2041	5.00–5.50	123	123
Series 2011B, WHCFA Revenue Bonds	2021	3.50–5.00	32	42
Series 2011C, OFA Revenue Bonds	2026	3.50–5.00	13	15
Series 2012A, WHCFA Revenue Bonds	2042	3.00–5.00	471	480
Series 2012B, WHCFA Revenue Bonds	2042	4.00–5.00	100	100
Series 2013A, OFA Revenue Bonds	2024	5.00	48	54
Series 2013A, CHFFA Revenue Bonds	2037	4.00–5.00	325	325
Series 2013C, CHFFA Revenue Bonds	2043	5.00	110	110
Series 2013D, Direct Obligation Notes	2023	4.38	252	252
Series 2013D, CHFFA Revenue Bonds	2043	5.00	110	110
Series 2014A, CHFFA Revenue Bonds	2038	4.00–5.00	269	270
Series 2014B, CHFFA Revenue Bonds	2044	4.25–5.00	119	119
Series 2014C, WHCFA Revenue Bonds	2044	4.00–5.00	92	92
Series 2014D, WHCFA Revenue Bonds	2041	5.00	179	179
Series 2015A, WHCFA Revenue Bonds	2045	4.00	78	78
Series 2015C, OFA Revenue Bonds	2045	4.00–5.00	71	71
Series 2016A, CHFFA Revenue Bonds	2047	2.50–5.00	448	448
Series 2016B, CHFFA Revenue Bonds	2036	1.25–4.00	286	286
Series 2016H, Direct Obligation Bonds	2036	2.75	300	300
Series 2016I, Direct Obligation Bonds	2047	3.74	400	400
Series 2018A, Direct Obligation Bonds	2048	4.00	350	—
Series 2018B, WHCFA Revenue Bonds	2033	5.00	142	—
Total fixed rate			5,146	4,874

	Maturing through	Effective interest rate (1) 2018	Effective interest rate (1) 2017	Unpaid principal 2018	Unpaid principal 2017
Variable rate:					
Series 2012C, WHCFA Revenue Bonds	2042	1.44 %	0.86 %	$ 80	80
Series 2012D, WHCFA Revenue Bonds	2042	1.44	0.86	80	80
Series 2012E, Direct Obligation Notes	2042	1.99	1.08	226	229
Series 2013C, OFA Revenue Bonds	2022	2.30	1.79	—	57
Series 2016C, LHFDC Revenue Bonds	2030	1.98	0.86	36	37
Series 2016D, WHCFA Revenue Bonds	2036	1.95	1.34	103	106
Series 2016E, WHCFA Revenue Bonds	2036	1.88	1.26	103	106
Series 2016F, MFFA Revenue Bonds	2026	1.85	1.23	42	46
Series 2016G, Direct Obligation Notes	2047	1.97	1.08	100	100
Total variable rate				770	841
Wells Fargo Credit Facility	2019	2.39	1.73	110	110
Wells Fargo Credit Facility	2021	2.52	1.63	105	369
Unpaid principal, master trust debt				6,131	6,194
Premiums, discounts, and unamortized financing costs, net				155	148
Master trust debt, including premiums and discounts, net				6,286	6,342
Other long-term debt				382	278
Total debt				$ 6,668	6,620

(1) Variable rate debt and credit facilities carry floating interest rates attached to indexes, which are subject to change based on market conditions.

In January 2018, the Health System issued $492 of Series 2018A and 2018B revenue bonds and direct obligation notes. The intended uses of funds included refinancing legacy SJHS and PHS master trust debt and repayment of outstanding lines of credit.

In connection with the Series 2018A-B issuance, the Health System recorded losses due to extinguishment of debt of $6 in the year ended December 31, 2018, which was recorded in net nonoperating (losses) gains in the accompanying combined statements of operations.

In November 2017, the Health System obtained a Well Fargo Bridge Loan for $110 and repaid the CHFFA Series 2013B revenue bonds.

The following table reflects classification of long-term debt obligations in the accompanying combined balance sheets as of December 31:

		2018	2017
Current portion of long-term debt	$	300	78
Short-term master trust debt		110	57
Long-term debt, classified as a long-term liability		6,258	6,485
Total debt	$	6,668	6,620

Short-term master trust debt represents debt issues with remarketing provisions unsupported by credit facilities with mandatory redemption within one year of December 31, 2018 and 2017.

(b) Other Long-Term Debt

Other long-term debt consists of the following as of December 31:

		2018	2017
Capital leases	$	255	152
Notes payable		117	105
Bonds not under master trust indenture and other		10	21
Total other long-term debt	$	382	278

(c) Debt Service

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

		Master trust	Other	Total
2019	$	285	15	300
2020		80	17	97
2021		189	16	205
2022		82	16	98
2023		365	13	378
Thereafter		5,130	305	5,435
Scheduled principal payments of long-term debt	$	6,131	382	6,513

(d) Derivative Instruments

The Health System uses interest rate swap agreements to manage interest rate risk associated with its outstanding debt. As of December 31, 2018 and 2017, the Health System had interest rate swap contracts with a total current notional amount totaling $453 and $467, respectively, with varying expiration dates. The interest rate swap agreements do not meet the criteria for hedge accounting and all changes in the valuation are recognized as a component of net nonoperating (losses) gains in the accompanying combined statements of operations. Settlements related to these agreements are recognized as a component of interest, depreciation, and amortization expense in the accompanying combined statements of operations. For the years ended December 31, 2018 and 2017, the change in valuation was a gain of $17 and $4, respectively, and settlements recognized as a component of interest expense were $9 and $12, respectively.

Derivative financial instruments are recorded at fair value taking into consideration the Health System's and the counterparties' nonperformance risk. The fair value of the interest rate swaps is based on independent valuations obtained and are determined by calculating the value of the discounted cash flows of the differences between the fixed interest rate of the interest rate swaps and the counterparty's forward London Interbank Offered Rate curve, which is the input used in the valuation, taking also into account any nonperformance risk. Collateral posted for the interest rate swaps consist of cash and U.S. government securities, which are both categorized as Level 1 financial instruments.

As of December 31, 2018 and 2017, the fair value of outstanding interest rate swaps was in a net liability position of $84 and $101, respectively, and is included in other liabilities in the accompanying combined balance sheets. The Health System had no collateral posted in connection with the outstanding swap agreements as of December 31, 2018. Collateral posted in connection with the outstanding swap agreements as of December 31, 2017 was $6 and was included in other assets in the accompanying combined balance sheets.

The following tables present the fair value of swaps and related collateral:

	December 31,	Fair value measurements at reporting date using		
	2018	Level 1	Level 2	Level 3
Liabilities under interest rate swaps	$ 84	—	84	—

	December 31,	Fair value measurements at reporting date using		
	2017	Level 1	Level 2	Level 3
Cash collateral held by swap counterparty	$ 6	6	—	—
Liabilities under interest rate swaps	101	—	101	—

(6) Retirement Plans

(a) Defined Benefit Plans

The Health System sponsors various frozen defined benefit retirement plans. The measurement dates for the defined benefit plans are December 31. A rollforward of the change in projected benefit obligation and change in the fair value of plan assets for the defined benefit plans is as follows:

		2018	2017
Change in projected benefit obligation:			
Projected benefit obligation at beginning of year	$	2,741	2,680
Service cost		27	23
Interest cost		106	114
Actuarial (gain) loss		(153)	110
Benefits paid and other		(186)	(186)
Projected benefit obligation at end of year		2,535	2,741
Change in fair value of plan assets:			
Fair value of plan assets at beginning of year		1,686	1,559
Actual return on plan assets		(130)	218
Employer contributions		99	95
Benefits paid and other		(186)	(186)
Fair value of plan assets at end of year		1,469	1,686
Funded status		(1,066)	(1,055)
Unrecognized net actuarial loss		526	495
Unrecognized prior service cost		1	3
Net amount recognized	$	(539)	(557)
Amounts recognized in the combined balance sheets consist of:			
Current liabilities	$	(1)	(1)
Noncurrent liabilities		(1,065)	(1,054)
Unrestricted net assets		527	498
Net amount recognized	$	(539)	(557)
Weighted average assumptions:			
Discount rate		4.60 %	4.00 %
Rate of increase in compensation levels		3.50	3.50
Long-term rate of return on assets		6.50	6.50

(Continued)

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

		2018	2017
Components of net periodic pension cost:			
Service cost	$	27	23
Interest cost		106	114
Expected return on plan assets		(105)	(102)
Amortization of prior service cost		1	1
Recognized net actuarial loss		26	25
Net periodic pension cost	$	55	61
Special recognition – settlement expense	$	26	25

Certain plans sponsored by the Health System allow participants to receive their benefit through a lump-sum distribution upon election. When lump-sum distributions exceed the combined total of service cost and interest cost during a reporting period settlement expense is recognized. Settlement expense represents the proportional recognition of unrecognized actuarial loss and prior service cost. Settlement expense for the years ended December 31, 2018 and 2017 is included in net nonoperating (losses) gains in the accompanying combined statements of operations.

The accumulated benefit obligation was $2,488 and $2,672 at December 31, 2018 and 2017, respectively.

The following pension benefit payments reflect expected future service. Payments expected to be paid over the next 10 years are as follows:

2019	$	182
2020		187
2021		192
2022		193
2023–2028		1,073
	$	1,827

The Health System expects to contribute approximately $99 to the defined benefit plans in 2019.

The expected long-term rate of return on plan assets is the expected average rate of return on the funds invested currently and on funds to be invested in the future in order to provide for the benefits included in the projected benefit obligation. The Health System used 6.5% in calculating the 2018 and 2017 expense amounts. This assumption is based on capital market assumptions and the plan’s target asset allocation.

The Health System continues to monitor the expected long-term rate of return. If changes in those parameters cause 6.5% to be outside of a reasonable range of expected returns, or if actual plan returns over an extended period of time, suggest that general market assumptions are not representative of expected plan results, the Health System may revise this estimate prospectively.

The target asset allocation and expected long-term rate of return on assets (ELTRA) were as follows at December 31:

	2018 Target	2018 ELTRA	2017 Target	2017 ELTRA
Cash and cash equivalents	2 %	2%–3%	2 %	2%–3%
Equity securities	45	7%–8%	45	7%–8%
Debt securities	33	3%–4%	33	3%–4%
Other securities	20	5%–8%	20	5%–8%
Total	100 %	6.5 %	100 %	6.5 %

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

	December 31, 2018	Fair value measurements at reporting date using		
		Level 1	Level 2	Level 3
Assets:				
Cash and cash equivalents	$ 81	81	—	—
Equity securities:				
Domestic	226	226	—	—
Foreign	61	61	—	—
Mutual funds	103	103	—	—
Domestic debt securities:				
State and government	266	208	58	—
Corporate	122	—	122	—
Other	15	—	15	—
Foreign debt securities	40	—	40	—
Commingled funds	141	141	—	—
Investments measured using NAV	487			
Transactions pending settlement, net	(73)			
Total	$ 1,469			

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

	December 31, 2017	Fair value measurements at reporting date using Level 1	Level 2	Level 3
Assets:				
Cash and cash equivalents	$ 68	68	—	—
Equity securities:				
Domestic	177	177	—	—
Foreign	48	48	—	—
Mutual funds	127	127	—	—
Domestic debt securities:				
State and government	272	210	62	—
Corporate	129	—	129	—
Other	13	—	13	—
Foreign debt securities	30	—	30	—
Commingled funds	170	170	—	—
Investments measured using NAV	720			
Transactions pending settlement, net	(68)			
Total	$ 1,686			

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

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

	Fair value 2018	Fair value 2017	Redemption frequency	Redemption notice period
Hedge funds:				
Long/short equity	$ 43	52	Monthly or quarterly	30–65 days
Credit and other	61	56	Monthly or quarterly	90 days
Real assets	53	92	Monthly	30 days
Risk parity	108	130	Monthly	5–15 days
Commingled	222	390	Monthly	6–30 days
Total	$ 487	720		

The Health System's defined benefit plans also allow certain investment managers to use derivative financial instruments (futures and forward currency contracts) to manage interest rate risk related to the plans' fixed-income holdings. The investment managers have executed master netting arrangements with the counterparties of the futures and forward currency purchase and sale contracts whereby the financial instruments held by the same counterparty are legally offset as the instruments are settled. The following table presents gross investment derivative assets and liabilities reported on a net basis at fair value included in the plans' assets as of December 31:

		2018	2017
Derivative assets:			
Futures contracts	$	724	926
Foreign currency forwards and other contracts		4	5
Total derivative assets	$	728	931
Derivative liabilities:			
Futures contracts	$	(724)	(926)
Foreign currency forwards and other contracts		(3)	(4)
Total derivative liabilities	$	(727)	(930)

(b) Defined Contribution Plans

The Health System sponsors various defined contribution retirement plans that cover substantially all employees. The plans provide for employer matching contributions in an amount equal to a percentage of employee pretax contributions, up to a maximum amount. In addition, the Health System makes contributions to eligible employees based on years of service. Retirement expense related to these plans was $513 and $478 in 2018 and 2017, respectively, and is reflected in salaries and benefit expense in the accompanying combined statements of operations.

(7) Self-Insurance Liabilities

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

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

At December 31, 2018 and 2017, the estimated liability for future costs of professional and general liability claims was $393 and $357, respectively. At December 31, 2018 and 2017, the estimated workers' compensation obligation was $351 and $309, respectively. Both are recorded in other current liabilities and other liabilities in the accompanying combined balance sheets.

(8) Commitments and Contingencies

(a) Commitments

Firm purchase commitments, primarily related to construction and equipment and software acquisition, at December 31, 2018 are approximately $534.

(b) Operating Leases

Future minimum lease commitments under noncancelable operating leases for the next five years and thereafter are as follows:

2019	$	222
2020		206
2021		183
2022		162
2023		144
Thereafter		727
	$	1,644

Rental expense, including month-to-month leases and contingent rents, was $411 and $382 for the years ended December 31, 2018 and 2017, respectively, and is included in other expenses in the accompanying combined statements of operations.

(c) Litigation

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

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

(9) Functional Expenses

Operating expenses classified by their natural classification on the combined statements of operations are presented by their functional classifications as follows for the years ended December 31:

	2018								
	Program Activities					Supporting Activities			
	Hospitals	Health plans and accountable care	Physician and outpatient	Long-term care, home care, and hospice	Total programs	General and administrative	Other	Total supporting	Total operating expenses
Salaries and benefits	$ 6,964	119	2,319	577	9,979	1,821	83	1,904	11,883
Supplies	2,920	1	279	114	3,314	—	249	249	3,563
Purchased healthcare services	13	2,349	36	16	2,414	—	—	—	2,414
Interest, depreciation, and amortization	815	7	78	19	919	433	8	441	1,360
Purchased services, professional fees and other	3,089	265	1,051	120	4,525	413	105	518	5,043
Restructuring costs	—	—	—	—	—	162	—	162	162
Total operating expenses	$ 13,801	2,741	3,763	846	21,151	2,829	445	3,274	24,425

	2017								
	Program Activities					Supporting Activities			
	Hospitals	Health plans and accountable care	Physician and outpatient	Long-term care, home care, and hospice	Total programs	General and administrative	Other	Total supporting	Total operating expenses
Salaries and benefits	$ 6,746	117	2,148	516	9,527	1,831	106	1,937	11,464
Supplies	2,812	1	241	97	3,151	—	239	239	3,390
Purchased healthcare services	23	2,462	38	16	2,539	—	—	—	2,539
Interest, depreciation, and amortization	810	7	78	18	913	386	8	394	1,307
Purchased services, professional fees and other	2,672	196	918	104	3,890	470	100	570	4,460
Total operating expenses	$ 13,063	2,783	3,423	751	20,020	2,687	453	3,140	23,160

Supporting activities include costs that are not controllable by operational leadership. Health System leadership drives these costs, which benefit the entire Health System. Costs that are controllable by operational leadership are allocated to the respective program activities.

PROVIDENCE ST. JOSEPH HEALTH

Supplemental Schedule – Obligated Group Combining Balance Sheets Information

December 31, 2018 and 2017

(In millions of dollars)

	2018			2017		
Assets	**Obligated Group**	**Nonobligated, eliminations, Other**	**Total combined**	**Obligated Group**	**Nonobligated, eliminations, Other**	**Total combined**
Current assets:						
Cash and cash equivalents	$ 1,027	570	1,597	787	584	1,371
Accounts receivable, net	2,127	130	2,257	2,148	74	2,222
Supplies inventory	282	11	293	270	7	277
Other current assets	789	69	858	1,103	54	1,157
Current portion of assets whose use is limited	339	315	654	256	224	480
Total current assets	4,564	1,095	5,659	4,564	943	5,507
Assets whose use is limited	7,145	2,454	9,599	7,580	2,406	9,986
Property, plant, and equipment, net	10,287	584	10,871	10,496	459	10,955
Other assets	1,932	(632)	1,300	1,732	(535)	1,197
Total assets	$ 23,928	3,501	27,429	24,372	3,273	27,645
Liabilities and Net Assets						
Current liabilities:						
Current portion of long-term debt	$ 296	4	300	76	2	78
Master trust debt classified as short-term	110	—	110	57	—	57
Accounts payable	984	114	1,098	624	60	684
Accrued compensation	1,109	93	1,202	1,033	78	1,111
Other current liabilities	1,188	647	1,835	1,623	668	2,291
Total current liabilities	3,687	858	4,545	3,413	808	4,221
Long-term debt, net of current portion	6,126	132	6,258	6,457	28	6,485
Pension benefit obligation	1,065	—	1,065	1,054	—	1,054
Other liabilities	484	686	1,170	509	630	1,139
Total liabilities	11,362	1,676	13,038	11,433	1,466	12,899
Net assets:						
Net assets without donor restrictions	11,739	1,417	13,156	12,178	1,367	13,545
Net assets with donor restrictions	827	408	1,235	761	440	1,201
Total net assets	12,566	1,825	14,391	12,939	1,807	14,746
Total liabilities and net assets	$ 23,928	3,501	27,429	24,372	3,273	27,645

See accompanying independent auditors' report

PROVIDENCE ST. JOSEPH HEALTH

Supplemental Schedule – Obligated Group Combining Statements of Operations Information

Years ended December 31, 2018 and 2017

(In millions of dollars)

	2018			2017		
	Obligated Group	Nonobligated, eliminations, Other	Total combined	Obligated Group	Nonobligated, eliminations, Other	Total combined
Operating revenues:						
Net patient service revenues	$ 18,439	670	19,109	17,630	506	18,136
Provision for bad debts	(111)	—	(111)	(243)	(26)	(269)
Net patient service revenues less provision for bad debts	18,328	670	18,998	17,387	480	17,867
Other revenues	1,768	3,662	5,430	1,844	3,452	5,296
Total operating revenues	20,096	4,332	24,428	19,231	3,932	23,163
Operating expenses:						
Salaries and benefits	10,643	1,240	11,883	10,391	1,073	11,464
Supplies	3,311	252	3,563	3,194	196	3,390
Interest, depreciation, and amortization	1,273	87	1,360	1,232	75	1,307
Purchased services, professional fees, and other	4,102	3,355	7,457	3,827	3,172	6,999
Total operating expenses before restructuring costs	19,329	4,934	24,263	18,644	4,516	23,160
Excess of revenue over expenses from operations before restructuring costs	767	(602)	165	587	(584)	3
Restructuring costs	162	—	162	—	—	—
Excess (deficit) of revenues over expenses from operations	605	(602)	3	587	(584)	3
Net nonoperating (losses) gains:						
Loss on extinguishment of debt	(6)	—	(6)	—	—	—
Investment (loss) income, net	(330)	(36)	(366)	773	109	882
Other	(87)	11	(76)	(4)	(101)	(105)
Total net nonoperating (losses) gains	(423)	(25)	(448)	769	8	777
(Deficit) excess of revenues over expenses	$ 182	(627)	(445)	1,356	(576)	780

See accompanying independent auditors' report.