RK SB
Health Care Consulting

210 MacCorkle Avenue, S.E., Charleston, West Virginia 25314
Phone: 304.343.2462 • Fax: 304.343.3083

RECEIVED
MAY 29 2020
West Virginia Healthcare Authority

May 29, 2020

Barbara Skeen, Director
Certificate of Need
WV Health Care Authority
100 Dee Drive, Suite 201
Charleston, West Virginia 25311

Dear Ms. Skeen:

Re: St. Mary's Medical Center, Inc.
CON File #20-2-11852-P

Enclosed is the certificate of need application submitted on behalf of St. Mary's Medical Center, Inc. related to the above cited CON file for the development of an ambulatory health care facility in Huntington, West Virginia. Also enclosed is the filing fee in the amount of $25,000.

If you have any questions or require further clarification, please do not hesitate to contact me.

Sincerely,

Raymona A. Kinneberg

Raymona A. Kinneberg
President

Enclosure - Application

c: Consumer Advocate

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Phone: 304.343.2462 • Fax: 304.343.3083

ST. MARY'S MEDICAL CENTER, INC.

Acquisition of HIMG

RECEIVED
MAY 29 2020
West Virginia Healthcare Authority

Certificate of Need Applicant:

St. Mary's Medical Center, Inc.

CON File #20-2-11852-P

For further information, please contact:

RKSB Health Care Consulting, Inc.
210 MacCorkle Avenue, SE
Charleston, WV 25314
(304) 343-2462

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Health Care Consulting

210 MacCorkle Avenue, S.E., Charleston, West Virginia 25314
Phone: 304.343.2462 • Fax: 304.343.3083

RECEIVED

MAY 29 2020

West Virginia Healthcare Authority

The State of West Virginia

The West Virginia Health Care Authority
Certificate of Need Division
100 Dee Drive
Charleston, West Virginia 25311
(304) 558-7000

St. Mary's Medical Center, Inc.

Acquisition of HIMG

CON File #20-2-11852-H

For further information, please contact:

RKSB Health Care Consulting, Inc.
210 MacCorkle Avenue, SE
Charleston, WV 25314
(304) 343-2462

St. Mary's Medical Center, Inc
CON File #20-2-11852-P

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St. Mary's Medical Center, Inc.
CON File #20-2-11852-P

LIST OF EXHIBITS

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SECTION A: IDENTIFICATION OF THE APPLICANT

Note: The applicant is the governing body or person proposing a new institutional health service and who is, or will be, the licensee of the health care facility in which the service will be located. In those cases not involving a licensed health care facility, the governing body or person proposing to provide the service is the applicant. Incorporators or promoters who will not constitute the governing body or person responsible for the new service may not be the applicant.

1.

St. Mary's Medical Center, Inc.
Name of Applicant

2900 First Avenue
Address of Applicant

Huntington	Cabell	WV	25702
City	**County**	**State**	**Zip Code**

Todd Campbell, President/CEO — (304) 526-1270
Name and Title of Chief Executive Officer — **Telephone**

2.

Huntington Internal Medicine Group
Name of Facility at Which Project Will Be Developed

Acquisition of HIMG
Project Name

5170 U.S. Route 60 East
Address

Huntington	Cabell	WV	25705
City	**County**	**State**	**Zip Code**

Medicare Provider Number:	To be applied for
Medicaid Provider Number:	To be applied for
Type of License (attach copy):	No license for HIMG practice; St. Mary's Medical Center, Inc. – Acute Care Hospital (See Exhibit A-1)

3. **Person to contact regarding this application:**

Raymona A. Kinneberg, President
Name and Title

RKSB Health Care Consulting, Inc.
Organization

210 MacCorkle Avenue S. E.
Address

Charleston	Kanawha	WV	25314
City	**County**	**State**	**Zip Code**

WORK Email: raymona@rksbhcc.com

4.

Type of Project: Ambulatory Care Center

5. **Check the appropriate category, which describes the Applicant.**

PROPRIETARY	NON-PROFIT	GOVERNMENTAL
____ Individual	X Corporation	____ State
____ Corporation	____ Church	____ County
____ General Partnership	____ Other (Specify)	____ Other (Specify)
____ Limited Partnership	____	____
____ Limited Liability Partnership		
____ Limited Liability Company		
____ Other (Specify)	____	

6. **Attach certificate of incorporation and filed articles of incorporation or certificate of limited partnership. If out-of-state corporation, attach a copy of the West Virginia certificate of authority. If there is no filing requirement**

with the Secretary of State, attach other proof of authorization to do business in the State.

Please see Exhibit A-2.

7. **List the current membership of the Board of Directors and principal officers of the corporation. If a partnership, provide the names of all general partners. Do not provide addresses or personally identifiable information.**

Please see Exhibit A-3.

8. **If an existing facility, list the owner(s) of record if other than the applicant.**

Huntington Internal Medicine Group is owned by Ultimate Health Services, Inc.

Hospital License

STATE OF WEST VIRGINIA
Department of Health and Human Resources

Med/Surg	288	SNF	19
ICU/CCU	44		
Obstetric	14		
Psychiatric	28		

Total Beds: 393

License No. 46

A License is hereby granted to **St. Mary's Medical Center**

To operate a **General Hospital to be known as St. Mary's Medical Center**

Located at **2900 First Avenue** *(Street)* **Huntington, West Virginia 25702** *(City)* **Cabell** *(County)*

This License *shall be effective from* ***January 1, 2020*** *and shall expire on* **June 30, 2020** *unless continued pursuant to any applicable provision of the West Virginia Code. This License shall not be assignable or transferable and shall be subject to revocation at any time for failure to comply with provisions of the West Virginia Code or of the West Virginia Legislative Rules.*

December 20, 2019

Director, Office of Health Facility Licensure and Certification ***Date***

THIS LICENSE MUST BE POSTED IN A CONSPICUOUS PLACE ON THE PREMISES

Certificate of Authority

State of West Virginia

Certificate

I, Joe Manchin III, Secretary of State of the State of West Virginia, hereby certify that

originals of the Articles of Amendment to the Articles of Incorporation of

ST. MARY'S HOSPITAL OF HUNTINGTON, INC.

are filed in my office, signed and verified, as required by the provisions of West Virginia Code §31-1-31 and conform to law. Therefore, I issue this

CERTIFICATE OF AMENDMENT TO THE ARTICLES OF INCORPORATION

changing the name of the corporation to

ST. MARY'S MEDICAL CENTER, INC.

and I attach to this certificate a duplicate original of the Articles of Amendment.

Given under my hand and the Great Seal of the State of West Virginia on this day of August 15, 2002

Secretary of State

Board of Directors

ST. MARY'S MEDICAL CENTER
2020 BOARD OF DIRECTORS

Carolyn Bagby

David Fox, President

Sr. Mary Grace Barile, Secretary

Floyd Harlow, Treasurer

Jeff Leaberry, M.D.

Matt Miller

Tim Millne

Vickie Smith

SECTION B: AUTHORIZATION TO PURSUE THE PROJECT

1. **Attach written authorization of the governing body's approval of the proposal and its written authorization empowering the signer of the application, the contact person(s) listed in Section A and any other individuals to act on behalf of the Applicant during the course of this review.**

   See Exhibit B-1.

Resolutions

RESOLUTION OF THE BOARD OF DIRECTORS
OF ST. MARY'S MEDICAL CENTER, INC.

WHEREAS, St. Mary's Medical Center, Inc. ("the Hospital") has entered into negotiations to purchase the assets of Ultimate Health Services, Inc. d/b/a Huntington Internal Medicine Group ("HIMG");

WHEREAS, the Board of Directors of the Hospital has reviewed the proposed transaction and has determined that it is in the Hospital's best interests to proceed with the purchase of the HIMG assets under the terms and conditions set forth in an asset purchase agreement and related documents ("the Agreement"); and

WHEREAS, the purchase of assets of HIMG requires that a Certificate of Need be obtained from the West Virginia Health Care Authority.

NOW, THEREFORE, BE IT RESOLVED that the Hospital be, and it hereby is, authorized to develop an ambulatory health care facility in Huntington, West Virginia through the acquisition of the assets and employment of the physicians and other practitioners of HIMG;

BE IT FURTHER RESOLVED that the Hospital be, and it hereby is, authorized to file an application for a Certificate of Need with the West Virginia Health Care Authority in conjunction with said project;

BE IT FURTHER RESOLVED that Todd Campbell, President and CEO and Angela Swearingen, Vice President of Finance/CEO, or either of them, are hereby authorized to execute said application on behalf of the Hospital; and

BE IT FURTHER RESOLVED that Raymona A. Kinneberg be, and she hereby is, authorized to serve as the contact person on behalf of the Hospital with the West Virginia Health Care Authority in connection with said application for a certificate of need.

CERTIFICATE

I, Tammy Meadows, Recording Secretary for the Board of Directors of St. Mary's Medical Center, Inc., do hereby certify that the resolution set forth above was adopted by the Board of Directors at a regular meeting of the Board of Directors held on April 28, 2020, at which meeting a quorum was present and voting.

Signed: Tammy J. Meadows Date: 4/28/2020

SECTION C: DESCRIPTION OF THE PROJECT

1. Generally describe the project. The description should include:

- **Specific services to be provided;**
- **Proposed service area and population to be served;**
- **Objectives of the project;**
- **Components of the project;**
- **General organization and management structure; and**
- **Capital expenditures associated with the project.**
  - **Capital expenditure is defined at W.Va. Code § 16-2D(10).**
  - **Expenditure minimum is defined at W.Va. Code § 16-2D-2(15); the expenditure minimum is adjusted yearly on or before December 31 of each year and is posted on the Authority's website.**

St. Mary's Medical Center, Inc. d/b/a St. Mary's Medical Center ("St. Mary's") is a 393 bed acute care hospital located in Huntington, West Virginia. St. Mary's serves residents of Cabell, Wayne and Lincoln counties in West Virginia and Lawrence County, Ohio and the surrounding area. St. Mary's is part of Mountain Health Network ("MHN") whose hospital members are St. Mary's and Cabell-Huntington Hospital, Inc. ("CHHI").

St. Mary's proposes acquiring substantially all the assets and employing the physicians and staff of Ultimate Health Services, Inc. d/b/a Huntington Internal Medicine Group ("HIMG"). This will result in the development of an ambulatory health care facility replacing the "private office practice" currently operated by HIMG. HIMG is a multi-specialty physician practice employing 77 physicians and other practitioners offering the following medical services: internal medicine, family medicine, cardiology, pulmonary, gastroenterology, oncology, rheumatology, radiology, endocrinology, nephrology, neurology, ophthalmology, plastic and reconstructive surgery, surgery, urology, pain management, podiatry, otolaryngology ("ENT"), and dermatology. HIMG serves Cabell and Wayne counties in West Virginia and Lawrence County, Ohio and the surrounding area. HIMG also has an ambulatory surgery center whose services are limited to endoscopic procedures (See In Re: Ultimate Health Services, Inc.; CON File #03-2-7616-X).

The objective of the project is to continue to provide multi-specialty medicine services to the existing patients of the practice and to see additional patients within available capacity.

The components of the project include:

- HIMG enters into an agreement with St. Mary's to acquire the practice;

- St. Mary's employs the physicians and staff of HIMG's practice; and
- St. Mary's begins operating the physician practice site.

The estimated capital cost of the project is projected to be approximately $10,550,000.

2. **If the facility or service is/will be managed or operated by someone other than the owner, specify and explain the relationship. Attach a copy of the contract or proposed contract under which the facility or service will be managed or operated.**

Not applicable.

3. Complete this table regardless of the effect the project has on the facility's bed capacity.

Bed Classification	Licensed Beds	CON Approved	Total Current	PROPOSED PROJECT CHANGES		Total Proposed Beds
				INCREASE	DECREASE	
Gen Med/Surg (adult)	288		288			288
Gen Med/Surg(Ped.)						
Psychiatric	28		28			28
Obstetrics	14		14			14
Orthopedic						
Chemical Detox						
Other Acute (Specify)						
Swing Beds						
Med/Surg intensive care	44		44			44
Cardiac intensive care	Included in ICU beds above		Included in ICU beds above			Included in ICU beds above
Pediatric intensive care						
Neonatal intensive care						
Burn Care						
Psych intensive care						
Other special care (specify)						
Other intensive care (specify)						
Total Acute Care	374		374			374

Bed Classification	Licensed Beds	CON Approved	Total Current	PROPOSED PROJECT CHANGES		Total Proposed Beds
				INCREASE	DECREASE	
Skilled nursing LTC	19		19			19
Intermediate LTC						
Psychiatric LTC						
I/DD						
Personal care						
Respite						
Rehabilitation						
Chronic disease						
Chemical dependency						
Other (Specify)						
Total Non-acute Care	19		19			19
Total Facility	393		393			393

4. **Complete the following table for each ancillary service affected by the project. Complete for most recently completed fiscal and first full year of operation after completion of the project. Use separate lines for inpatient and outpatient components of the same service. Define service units used and state all assumptions used on a separate sheet of paper and attach.**

Not applicable.

5. **Movable Equipment Cost**

a. **Equipment To Be Acquired By Purchase, Lease or Donation:**

Not applicable. Existing equipment owned by the practice will be included in the purchase price of substantially all the assets of the practice.

Equipment Description	Cost	Installation/ Renovation	Fair Market Value	Total Cost
TOTAL				

b. **Specify terms of maintenance agreement.**

Not applicable.

6. **For construction projects, complete or provide the following for each site under construction:**

a. **Description.**

b. **Location described in writing and shown on a map.**

c. **Acreage.**

d. **Purchase cost or documented appraised value. Attach a copy of appraisal report.**

e. **Estimated site development cost.**

f. **Documentation of availability.**

g. **Office of Health Facilities Licensure and Certification ("OHFLAC") survey form, if proposed facility is subject to licensure.**

Not applicable. There is no construction involved in this project.

7. **Provide one full-size set of schematic (single-line) drawings, to scale, of the project which show the relationships of the various departments or services to each other and the room arrangement in each department. Note the name of each room. Include reduced, but readable, copies in your application.**

Not applicable. There is no construction involved in this project.

8. **Provide a tabulation of square footage for each affected department of the facility and any proposed changes using the following format.**

Not applicable. There is no construction involved in this project.

9. **Capital Cost Of Project:**

Note: Complete only those subitems which apply to your project.

Costs should be based on timetable provided in Section D of this application. Review of cost increases, if necessary, will be based on delays in that timetable or rates of inflation that exceed the assumptions used to calculate costs.

a.	**Site acquisition costs:**	
	1. Purchase Price	**$10,500,000**
	2. Closing Costs	
	3. Other (specify)	
	Subtotal (a)	**$10,500,000**
b.	**Site Preparation costs:**	
	1. Demolition	
	2. Earthwork	
	3. Site Utilities	

4. Roads, Parking and Walks	
5. Other (specify)	
a.	
b.	
Subtotal (b)	N/A

c. Architectural & Engineering:

1. Architectural Fees	
2. Engineering Fees	
Subtotal (c)	N/A

d. Other Consultant Fees:

1. CON Application Preparation Fees	$10,000
2. CON Application Filing Fee	$25,000
3. Other (Legal Fees)	$6,000
Contingency	$9,000
Subtotal (d)	$50,000

e. Direct Construction Costs:

1. Cost of Materials	
2. Cost of Labor	
3. Fixed Equipment included in Construction Contract	
4. Contingency (__%)	
Subtotal (e)	N/A

f. Movable Equipment Costs:

From Section C, Question 5	N/A
Subtotal (f)	N/A

g. For all types of financing, complete the following applicable items:

1. Legal Fees:	
a. Bond Counsel*	
b. Underwriter's Counsel*	
c. Applicant's Counsel*	
d. Other	

*If no specific amount agreed to, state percentage or rate per hour and estimated number of hours.

2. Capitalized interest (interest earned less interest paid during construction)	
3. Feasibility Study	
4. Other (Specify)	
a.	
b.	
Subtotal (g)	N/A
TOTAL PROJECT COST	$10,550,000

Anticipated construction start and end dates on which cost estimates are based:

Not applicable.

Estimated annual inflation rate used to project costs: Not applicable.

SECTION D: PROJECT TIMETABLE

Provide a timetable for incurring the obligation for any capital expenditure associated with the project and for implementation of the project.

SIGNIFICANT PHASES OF PROJECT	ESTIMATED MONTHS SUBSEQUENT TO CON APPROVAL
Land (site) acquired	N/A
Final plans and specifications submitted to the Office of Health Facility Licensure & Certification	N/A
Financing arrangements completed	N/A
Initial capital expenditure obligated	Immediately
Construction contract secured and signed	N/A
Construction started	N/A
Remaining capital expenditure obligated	N/A
Equipment orders submitted	N/A
Construction completed	N/A
Request for substantial compliance review submitted to CON Program	Two Weeks
Project completed and in operation	2 months

SECTION E: **THE NEED AND ACCESSIBILITY OF THE POPULATION TO BE SERVED**

PLEASE NOTE that the Need Methodology of the applicable State Health Plan CON Standards (CON Standards) should be addressed under Section E.

1. **Identify the study area or service area for the proposed project as defined in the applicable CON standards. Please note that multiple Standards may apply. If the identified service area is not defined in the CON Standards, provide rationale for the area proposed.**

   The applicable standard is the Ambulatory Care Center standard approved by the Governor on October 5, 1992. The Ambulatory Care Center standard does not define service area. The proposed service area is Cabell and Wayne counties in West Virginia and Lawrence County, Ohio, consistent with historical experience of HIMG.

2. **In all cases provide an analysis of the need for the proposed project which, at a minimum, should address:**

   a. **Estimated population of the service area (current and future five years). (Data provided by the Authority shall be used; in addition, the applicant may propose to use other data - in which event, the source of the data must be stated as well as the rationale for using it.)**

      The population of the service area is provided in Exhibit E-1.

   b. **Calculation of need utilizing the methodology contained in the applicable CON standards (Data provided by the Authority must be used; in addition, a need calculation may be stated based on the data used in response to question 2.a. of this Section E.)**

      The applicable standard is the Ambulatory Care Center standard approved by the Governor on October 5, 1992.

AMBULATORY CARE CENTERS

II. GENERAL STANDARDS

A. NEED METHODOLOGY

For ambulatory care centers for which no specific need methodology is set forth in Section III, below, the following general need methodology shall be used. If a need methodology is specified for a particular type of ambulatory care facility in Section III of this standard, the general need methodology will apply only to those portions of the need methodology which are not specified.

All certificate of need applicants shall demonstrate, with specificity, that there is an unmet need for the proposed ambulatory care services, that the proposed services will not have a negative impact on the community by significantly limiting the availability and viability of other services or providers, and that the proposed services are the most cost effective alternative.

The applicant shall delineate the service area by documenting the expected areas around the ambulatory care facility from which the center is expected to draw patients. The applicant may submit testimony or documentation on the expected service area, based upon national data or statistics, or upon projections generally relied upon by professionals engaged in health planning or the development of health services.

See response to E.1. above.

The applicant shall document expected utilization for the services to be provided by the facility for the population within the service area. As used in this section, "expected utilization", in addition to the expected demand for the service, may be expressed as the number of providers typically required to serve any given population, or as the number of persons in a population that are typically serviced by a single provider. Where a population is known to have specific characteristics, such as age or disease rates, that affect utilization, then those characteristics may be taken into consideration.

This project relates to the acquisition of an existing multi-specialty physician practice. The practice includes primary care physicians, 16 physician specialties, podiatrists, audiologists, occupational and physical therapists, an optometrist, psychologist, and a dietitian. Please see Exhibit E-2 for the documentation of need based on one practitioner for a given number of residents. Please see Exhibit E-3 for number of each practitioner needed for the service area.

After establishing expected utilization or demand, the applicant shall estimate or document the number of existing providers within the service area and the extent to which the demand is being met by existing providers located within the service area. Where expected utilization is expressed as a number of providers typically serving a given population, it shall be sufficient to show that the ratio of providers to the population in the area is below the expected number. Providers located outside the service area need not be considered, absent specific showing that a provider located outside the service area is a major provider of services to the population within the service area.

See Exhibit E-3.

All certificate of need applicants shall demonstrate, with specificity, that there is an unmet need for the proposed ambulatory care services, that the proposed services will not have a negative impact on the community by significantly limiting the availability and viability of other services or providers, and that the proposed services are the most cost effective alternative.

Since this is an existing office practice, determination of unmet need is not applicable. Continuation of the practice as proposed through this acquisition is critical to providing medical services to the residents of the service area, including the active patients of the practice being acquired.

c. **Other need methodologies may be used in absence of a State Health Plan methodology or to supplement item b. (above).**

Not applicable.

d. **A map of the service area.**

Please see Exhibit E-4.

e. **A list of all of the existing providers of similar services and utilization rates for each of them.**

Since this is the acquisition of an existing primary care, this is not applicable. As noted above, there are other primary care physician practices in the service area. Utilization rates for the practices is unknown.

3. **What are the proposed hours and days of operation for the facility or health services?**

Existing hours will continue following the acquisition. St. Mary's will continue to operate HIMG Monday through Friday from 7:00 am to 4 pm and Saturday and Sunday from 9 am to 3 pm.

4. **What arrangements will be made for individuals requiring access to services during those hours that it is not operating?**

St. Mary's and CHHI, located in Huntington, are open 24 hours a day, seven days a week.

Service Area Population

Service Area Population

source: WVRRI March 2017 population projections, Ohio Office of Research - ODSA

County	2020	2025
Cabell	96,275	96,509
Wayne	39,851	39,219
Lawrence, OH	59,100	58,085
	195,226	193,813

Practitioner Per Population Ratios

Practitioner per Population Ratios

Primary Care

A study commissioned by the U.S. Department of Health and Human Services, Health Resources and Services Administration to develop revised guidelines for criteria for establishing MUAs and Health Professional Shortage Areas ("HPSA") sets the "preferred ratio of 1,500 people per full-time primary care physician as a central-tendency standard of adequate access."[1] The same study goes on to recommend setting the threshold for a medically underserved area as a physician to population ratio of 1:3,000.[2] In addition, the study states:

- Primary care physicians include family medicine, Pediatric, obstetrics/gynecology, and internal medicine.[3]
- FTE numbers may be adjusted to agree with actual availability[4]:
  - Physicians (MDs and DOs) count as 1 FTE.
  - Mid-levels (NPs, PAs, and CNMs) count as 0.5 FTE.
  - MD and DO interns and residents count as 0.1 FTE.

Specialty Physicians

The ratio of physician to population ratios for specialty physicians listed below were taken from the 2018 Physician Specialty Data Book issued by the Association of American Medical Colleges, Table 1.2. Number of People per Active Physicians by Specialty, 2017[5], included with this Exhibit.

Specialty	People per Physician
Dermatology	27,028
Endocrinology	43,458
Otolaryngology (ENT)	34,193
Gastroenterology	22,087
General Surgery	13,007
Specialty	People per Physician

---

1 Ricketts, Thomas C., Ph.D. et al. "Designating Places and Populations as Medically Underserved: a Proposal for a New Approach." Journal of Health Care for the Poor and Underserved 18 (2007): 567-589. 10 June 2008 <bhpr.hrsa.gov/shortage/designatingMUs.htm>. p. 573.

2 Ibid.

3 Ibid.

4 Ibid. p. 575

5 Center for Workforce Studies. Association of American Medical Colleges. "2018 Physician Specialty Data Book." 2018. Table 1.2. Number of People per Active Physicians by Specialty, 2017. https://www.aamc.org/data/workforce/reports/492558/1-2-chart.html. Accessed May 10, 2020.

Hemotology/Oncology	21,137
Nephrology	39,165
Neurology	23,745
Ophthalmology	17,317
Pain Management	60,939
Plastic Surgery	45,606
Pulmonary Disease	61,865
Rheumatology	55,385
Urology	31,831

Podiatric Medicine.

Nationally, there is approximately 1 podiatric medicine physicians to 20,408 population.[6]

Electrophysiology

Based on 2011 data, there is approximately 1 electrophysiology physician to 162,112 population. This is based on data from the US Census Bureau on estimated US population for 2011[7] and number of electrophysiology physicians in the US from American Board of Internal Medicine[8].

Psychologists

Based on 2017 data, there is approximately 1 psychologist to 1,946 population. This is based on data from the US Census Bureau on estimated US population for 2017[9] and number of psychologists in the US from Data USA[10].

---

6 Illinois Podiatric Medical Association. "Resources for Patients; Podiatry Facts and Statistics." https://www.ipma.net/page/15. Accessed August 26, 2019.

7 Vintage 2018 Population Estimates. Population Division. US Census Bureau. https://www.census.gov/library/visualizations/interactive/population-increase-2018.html#. Accessed May 11, 2020.

8 Data USA. https://datausa.io/profile/soc/physical therapits. Accessed May 11, 2020.

9 Vintage 2018 Population Estimates. Population Division. US Census Bureau. https://www.census.gov/library/visualizations/interactive/population-increase-2018.html#. Accessed May 11, 2020.

10 Anad, Rishi, MD. "Career Advice for Newly Trained Electrophysiologists." EP Lab Digest. Volume 12, Issue 3, March 2012. https://www.eplabdigest.com/articles/Career-Advice-Newly-Trained-Electrophysiologists. Accessed May 11, 2020.

Physical Therapists

Based on 2018 data, there is approximately 1 physical therapist to 1,314 population. This is based on data from the US Census Bureau on estimated US population for 2018[11] and number of physical therapists in the US from Data USA[12].

Occupational Therapists

Based on 2018 data, there is approximately 1 occupational therapist to 2,842 population. This is based on data from the US Census Bureau on estimated US population for 2018[13] and number of occupational therapists in the US from Data USA[14].

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11 Vintage 2018 Population Estimates. Population Division. US Census Bureau. https://www.census.gov/library/visualizations/interactive/population-increase-2018.html#. Accessed May 11, 2020.

12 Data USA. https://datausa.io/profile/soc/physical-therapists. Accessed May 11, 2020.

13 Vintage 2018 Population Estimates. Population Division. US Census Bureau. https://www.census.gov/library/visualizations/interactive/population-increase-2018.html#. Accessed May 11, 2020.

14 Data USA. https://datausa.io/profile/soc/occupational-therapists. Accessed May 11, 2020.

Need Assessment

Need Analysis

Practioner	Population Per Practioner	Need [1] in Service Area	Actual [2 3] in Service Area	Unmet Need
Primary Care	1,500	130.2	325	(194.8)
Dermatology	27,028	7.2	5	2.2
Endocrinology, Diabetes and Metabolism	43,458	4.5	8	(3.5)
Gastroenterology	22,087	8.8	9	(0.2)
General Surgery	13,007	15.0	21	(6.0)
Hematology and Oncology	21,137	9.2	7	2.2
Nephrology	30,165	6.5	10	(3.5)
Neurology	23,746	8.2	12	(3.8)
Opthalmology	17,310	11.3	13	(1.7)
Otolaryngology	34,193	5.7	5	0.7
Pain Medicine and Pain Management	60,939	3.2	6	(2.8)
Plastic Surgery	45,606	4.3	5	(0.7)
Pulmonary Disease	61,865	3.2	12	(8.8)
Rheumatology	55,385	3.5	3	0.5
Urology	32,831	5.9	10	(4.1)
Podiatric Medicine	20,408	9.6	12	(2.4)
Electrophysiology	162,112	1.2	2	(0.8)
Psychologists	1,946	100.3	48	52.3
Physical Therapists	1,314	148.6	37	111.6
Occupational Therapists	2,842	68.7	33	35.7

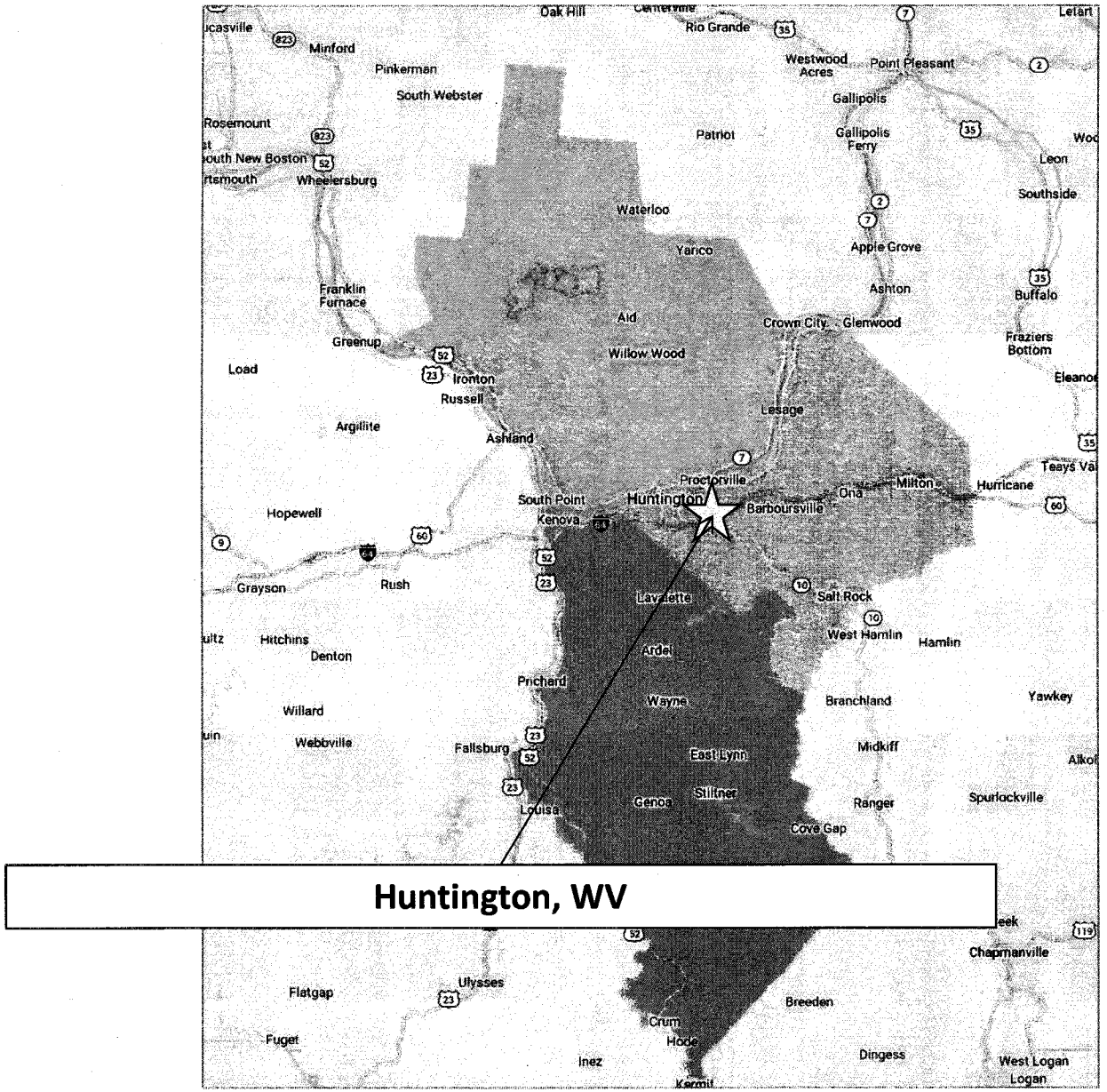
[1] *Service area Population divided by the population Per Practitioner*

[2] *WV Board of Medicine, WV Board of Osteopathic Medicine, eLicense Ohio Professional Licensure for all except WV psychologists, physical therapists, and occupational therapists*

[3] *Internet search compared againt WV Board of Physical Therapy, WV Board of Occupational Therapy and WV Board of Psychology active members lists for WV psychologists, physical therapists, and occupational therapists*

Service Area Map

St. Mary's Medical Center Ambulatory Health Care Facility Service Area Map



Huntington, WV

RK SB
Health Care Consulting

May 14, 2020

SECTION F: POLICIES FOR PATIENT ADMISSION AND PROVISION OF UNCOMPENSATED CARE

1. Describe the facility's policies for patient admission as listed; include copies of policies or of proposed policies, if available.

a. Medical criteria.

St. Mary's admission policies will remain unchanged as a result of this project. St. Mary's admits all patients in need of the emergency and medically necessary services it provides. In the case of the new practice location, all patients seeking medically necessary services from this multi-specialty practice will be admitted within available capacity.

b. Financial criteria.

St. Mary's will serve all persons in need of the medical services it provides without regard to source of payment. St. Mary's policy on Uncompensated (Charity) Care Plan is included as Exhibit F-1. As noted in that policy, St. Mary's "will make medically necessary services available on an inpatient or outpatient basis to individuals who cannot afford to pay for such services as determined by the Medical Center board of trustees." In addition, the policy states that St. Mary's "will provide services at no cost or below cost to those who are financially unable to pay for those services, limited by the economic health of the institution."

c. Other criteria related to non-discriminatory access to services and placement.

St. Mary's is committed to treating all persons with dignity, respect and compassion. As noted in Exhibit F-1, patients have the right to receive "quality medical care regardless of race, color, sex, handicap, religion, or national origin."

2. Specifically describe policies for provision of uncompensated care as listed.

a. Note the projected value of 1) uncompensated care and 2) charity care, consistent with financial projections in Section N.

Uncompensated care and charity care in the financial projections are based on historical experience of St. Mary's and HIMG.

b. Describe admissions screening procedure for medically indigent patients.

An individual unable to pay for medically necessary services must file an application. The application is reviewed, and a determination is made the approve or deny the application.

c. If applicable, describe the facility's progress in meeting its Hill-Burton obligation or other charity care policies or requirements.

Not applicable.

Uncompensated (Charity) Care Plan

ST. MARY'S MEDICAL CENTER
POLICY AND PROCEDURE MANUAL

Title:	Uncompensated (Charity) Care Plan	Type:	Medical Center Operations Manual
Section:	Finance	Prepared By:	Business Services
Approved By:	Policy & Procedure	# of Pages:	3

Policy:
St. Mary's Medical Center will make medically necessary services available on an inpatient or outpatient basis to individuals who cannot afford to pay for such services as determined by the Medical Center board of trustees.

The Medical Center will not discriminate to patients on the basis of race, color, sex, handicap, religion or national origin. Certain restrictions on patient admissions may be made due to the specialized nature of the medical care provided.

St. Mary's Medical Center will provide services at no cost or below cost to those who are financially unable to pay for those services, limited by the economic health of the institution. The quantity of no cost and below cost health care is limited to the amount which can reasonably be provided consistent with the maintenance of the economic well-being and fiscal soundness of the Medical Center.

St. Mary's Medical Center will not arbitrarily restrict the provisions of health services to certain individuals or groups.

St. Mary's Medical Center will post signs in all patient registration areas containing a statement of the existence of our obligation to provide free and below cost care and of the mechanism for receiving such care.

St. Mary's Medical Center will make available a written notice to each patient or their representative of the existence, criteria and mechanism for receiving such care. The Medical Center will create and maintain records demonstrating that such required criteria and mechanism are established. The Medical Center will record any and all requests for no cost or below cost care, the disposition, and the dollar amount of uncompensated care provided. In all instances, patient confidentiality will be protected and maintained. Aggregate data reflecting the number of requests for uncompensated care, the disposition of such requests and the dollar amount of uncompensated care provided shall be made available to the general public annually. The specific required information will be filed with the West Virginia Health Care Cost Review Authority.

Healthcare facilities must make uncompensated services available under the WV Tax Ad Valorem code 110-3-24 effective July 1, 1990.

Definitions:
Uncompensated Services is the term applied to health services made available at no charge or at

a reduced charge to persons unable to pay.

Procedure:

An individual notice of the availability of uncompensated services will be given to each patient or their representative prior to services being rendered, with the exception of emergency services. These notices shall be available in all registration areas of the Medical Center and shall include the most currently available *"Family Poverty Income Guidelines"* as published in the Federal Register.

Eligibility will be determined by comparing household family income against the income poverty guidelines for financial indigence; a ratio of total medical expenses to annual disposable income for medical indigence. Income is defined as the total annual cash receipts before taxes from all sources.

Financially Indigent. Uncompensated care shall include unreimbursed services to the financially indigent. Financially indigent shall mean uninsured or underinsured patients accepted for care with no obligation or a discounted obligation to pay for services rendered based on the Medical Center's eligibility system which may include: (a) income levels and means testing or other criteria for determining a patient's inability to pay; or (b) other criteria for determining a patient's inability to pay that are consistent with the Medical Center's mission and established policy. The federal poverty level shall serve as an index for the threshold below which patients receiving care at St. Mary's Medical Center are deemed financially indigent. Financially indigent services include non-covered services for patients eligible for the Medicaid program, services provided under county indigent care contracts, and other state or federal assistance programs for low income groups.

Medically Indigent. Uncompensated care shall include unreimbursed services to the medically indigent. Medically indigent shall mean patients who are responsible for their living expenses, but whose medical and hospital bills, after payment by third party payers, where applicable, exceed: (a) a specified percentage of the patient's annual gross income (i.e., catastrophic medical expenses) in accordance with the Medical Center's formal eligibility system in such instances where payment would require liquidation of assets critical to living or earning a living; or (b) the criteria for determining a patient's inability to pay.

While financial indigence is based strictly on an income level, medical indigence considers both income and the financial obligation for healthcare services to calculate the patient's ability to pay without liquidating assets critical to living or earning a living, such as a home, car, personal belongings, etc. Therefore, patients are considered for medically indigent status on a case by case basis. The patient would be required to provide documentation of income to determine if he/she is to be considered medically indigent. All patients are eligible to be considered for medically indigent status with the exception

of patients with income below 200% of the Federal poverty level as these patients are considered for some level of uncompensated care under the financially indigent category.

After reviewing the demographic data, the patient is considered medically indigent when the patient's total hospital account balance, after third party reimbursement (if any), is greater than 30% of the family's total gross annual income. For example, a patient with income of $40,000 and $20,000 in medical expenses, and no insurance would be responsible for $12,000 (30% of $40,000 = $12,000) of his account and the remaining $8,000 would be considered uncompensated care as medically indigent.

The Director of Business Services or his/her designee shall review all applications for uncompensated care. It is the applicant's responsibility to provide proof of income. Reasonable financial indigence benefits will be granted based on the following schedule:

2018 HHS Poverty Guidelines

Note: The 100% column shows the federal poverty level for each family size, and the percentage columns that follow represent income levels that are commonly used as guidelines for health programs.

For all states (except Alaska and Hawaii) and for the District of Columbia

Persons in	FPG	% of Charges Eligible for Uncompensated Care			
Family Unit	100%	80%	60%	40%	20%
1	$12,140	$16,146	$18,210	$24,280	$36,420
2	16,460	$21,892	$24,690	$32,920	$49,380
3	20,780	$27,637	$31,170	$41,560	$62,340
4	25,100	$33,383	$37,650	$50,200	$75,300
5	29,420	$39,129	$44,130	$58,840	$88,260
6	33,740	$44,874	$50,610	$67,480	$101,220
7	38,060	$50,620	$57,090	$76,120	$114,180
8	42,380	$56,365	$63,570	$84,760	$127,140
For each additional person, add	4,320	5,745.60	8,618.40	17,237	12,960

SOURCE: *Federal Register*, 83 FR 2642

Formed: 9/1/05
Revised 1/23/08; 4/08;6/15/2012; 2/12/2013; 02/11/2015; 02/01/2018

SECTION G: ANALYSIS OF ALTERNATIVES

1. **Describe how this proposal is the most desirable alternative as compared to maintaining the status quo and providing the service in a less restrictive setting in terms of:**

The status quo is not an option. HIMG determined that the practice wished to become employed physicians and discontinue the private practice of medicine. Given the close ties between HIMG and St. Mary's, St. Mary's determined acquiring the practice was the best option. The only other option was for St. Mary's not to acquire the practice, which would have meant ownership by an entity other than St. Mary's.

a. **Financial feasibility.**

As shown in Section N, acquisition of the practice is financially feasible.

b. **Extent of construction, renovation, and related capital costs.**

Not applicable. There is no construction or renovation involved in the proposed project.

c. **Capacity and utilization of existing providers of similar services in proposed service area [refer to Section E, item 2(e)].**

See Section E.

d. **Cost containment.**

Not applicable.

e. **Consumer input and participation.**

St. Mary's has consumer representation on its Board of Directors.

f. **Special considerations (if applicable):**

1. **Energy efficiency.**

2. **Improved access for medical and health professional training.**

3. **Enhancement of biomedical and behavioral research designed to meet a national need.**

Not applicable.

2. **What alternatives to the development of this proposal were considered?**

The option not to pursue acquisition of the practice was considered.

3. **Describe how this proposal will result in the efficient and effective delivery of services.**

The proposed acquisition will allow the continuance of multi-specialty physician services at the existing location.

4. **In the case of new construction, what alternatives to new construction, such as modernization or sharing arrangements, have been considered and have been implemented to the maximum extent practicable.**

Not applicable.

SECTION H: RELATIONSHIP TO EXISTING HEALTH CARE SYSTEM

1. **Describe the project's relationship to the existing health care system in the service area with regard to accessibility and continuity of services.**

   As discussed in Section C, strong ties exist between St. Mary's and HIMG, with St. Mary's operating an MRI unit at the HIMG location. The proposed acquisition will build on the ties between the practice and St. Mary's and MHN.

2. **Describe how patients will experience serious problems in obtaining care of the type proposed in the absence of the proposed new service.**

   This is an acquisition of an existing practice. Without the proposed acquisition, the practice would likely be acquired by an entity unrelated to St. Mary's or MHN.

3. **List and describe the nature of all working relationships and/or formal arrangements that have been made to assure shared and support services. Attach copies of all agreements or proposed agreements.**

   Not applicable.

SECTION I: RELATIONSHIP TO THE STATE HEALTH PLAN

1. **Address the CON Standard applicable to the proposed project. Please note that multiple Standards may apply. The CON Standards are available on the Authority's website** (www.hca.wv.gov).

2. **In formatting your responses, please repeat each section of the CON Standards before providing your responses.**

PLEASE NOTE that the Need Methodology of the applicable CON Standards should be addressed under Section E of this application. All other sections of the applicable CON Standards are addressed under Section I.

This project involves the acquisition of a multi-specialty physician practice in Huntington, Cabell County, West Virginia. The provision of these services by St. Mary's meets the definition of an ambulatory health care facility as defined by WV Code 16-2D-2(2). The applicable state health plan criteria are set forth in I.B.2.f. of the Ambulatory Care Center Standards.

AMBULATORY CARE CENTER STANDARDS

A. Need

The need for this project is discussed in Section E of this application.

B. Quality

Applicants seeking a certificate of need approval for the development of an ambulatory care center, or for a renovation or replacement facilities, shall demonstrate compliance with applicable licensing, certification, and/or accreditation standards, or submit a substantive and detailed plan to compliance with applicable requirements. All staff of the facility shall be in compliance with applicable standards.

All St. Mary's health care professionals are in compliance with applicable state licensing requirements. In addition, St. Mary's is accredited by The Joint Commission and all services provided by St. Mary's must be in compliance with The Joint Commission requirements. St. Mary's accreditation from The Joint Commission is included as Exhibit I-1.

All ambulatory care centers shall document written plans for the development and implementation of a quality assurance program which

meets acceptable standards as specified by any applicable accrediting organizations.

St. Mary's has a quality assurance program which meets The Joint Commission standards. This program applies to all St. Mary's operations. St. Mary's Quality Improvement and Patient Safety Plan is included as Exhibit I-2.

All ambulatory care centers shall demonstrate:

1. **suitability of physical plant, if applicable;**

   St. Mary's will enter into an agreement to lease the existing office currently occupied by the physician office practice, which is specifically designed for HIMG' practice.

2. **adequate staff;**

   As noted above, all St. Mary's health care professionals are in compliance with applicable state licensing requirements.

3. **effective treatment environment documented by written protocol;**

   St. Mary's will use the treatment protocols/clinical pathways developed by HIMG for use by all St. Mary's medical staff at the HIMG location.

4. **recognition of patient rights; and**

   St. Mary's policy on Patients Rights is included as Exhibit I-3. As indicated in the policy, it is St. Mary's "is committed to respecting the rights of all who entrust their care to" St. Mary's.

5. **an administrative/evaluation process.**

   St. Mary's is part of the MHN. The Chief Executive Officer of St. Mary's reports directly to the St. Mary's Board of Directors.

C. Continuum of Care

Ambulatory care centers will develop referral relationships and cooperative agreements with other health care providers as may be required to assure a continuum of care.

St. Mary's is part of MHN and has referral relationships with all MHN providers. In addition, St. Mary's has long standing ties to HIMG, including operating an MRI unit at HIMG under an agreement with HIMG. HIMG has immediate access to all services at both St. Mary's and CHHI including, but not limited to, inpatient and outpatient hospital services. St. Mary's physicians work closely with other health care providers in the county they serve, both those associated directly or indirectly with MHN and those unrelated to MHN to ensure their patients' needs are met.

D. **Cost**

The financial feasibility of a proposed ambulatory care center must be demonstrated through three years.

As shown in Section N, the practice is financially feasible and will have net income beginning in year one.

Costs and charges for services and procedures provided in an ambulatory care center shall be comparable to the cost and charges of facilities offering comparable services.

St. Mary's will use HIMG's fee schedule initially and transition to St. Mary's fee schedule.

Applicants must demonstrate in their financial projections that all indigent persons needing the services or procedures can be served without jeopardizing the financial viability of the project.

The financial impact projections in Section N assume uncompensated care and charity care are based on the historical experience of St. Mary's and HIMG.

Applicants must demonstrate that new services, facilities and technologies will not lead to unnecessary increases in costs.

Not applicable. There are no new services, facilities, or technologies.

E. Accessibility

Facilities shall comply with all applicable state and federal laws regarding accessibility to the disabled.

The HIMG office is compliance with ADA.

Preference will be given to applicants who demonstrate intent to provide services to all patients, without regard to their ability to pay.

St. Mary's serves all persons in need of the medical services it provides without regard to source of payment. St. Mary's obtains financial data to determine if the patient meets the requirements to receive financial assistance. Financial assistance and partial write-offs are based primarily on the family income in relation to the federal poverty guidelines. When appropriate, assets and the financial impact of a long-term catastrophic illness are taken into account. St. Mary's Uncompensated (Charity) Care Plan is included as Exhibit F-1.

F. Alternatives

Alternatives to new construction should be explored and applicants must demonstrate the need for any new construction proposed for the development of an ambulatory care center.

Not applicable. There is no construction related to this project.

Other alternatives which can assure the availability of the service at a lower or similar cost with improved accessibility shall be addressed.

The only alternative to this proposal is for St. Mary's not to acquire the practice. Since HIMG has decided it wishes to no longer remain in the private practice of medicine, this would mean that another entity would apply to acquire this practice.

G. Other

Notwithstanding their location in the ambulatory care center, nothing in this standard shall exempt from review certain health services major medical equipment, and/or facilities, which are subject to separate

certificate of need review pursuant to West Virginia Code. These include, but are not limited to:

Computerized Tomography
Proton Emission Tomography
Magnetic Resonance Imaging
Cardiac Catheterization
Radiation Therapy
Lithotripsy

Not applicable.

The Joint Commission Accreditation

St. Mary's Medical Center

Huntington, WV

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Hospital Accreditation Program

July 21, 2018

Accreditation is customarily valid for up to 36 months.

Craig W. Jones, FACHE
Chair, Board of Commissioners

ID #6434
Print/Reprint Date: 10/18/2018

Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

Quality Improvement and Patient Safety Plan

Quality Improvement and Patient Safety Plan 2019

Table of Contents

I. Introduction to Quality Improvement and Patient Safety

The Quality Improvement and Patient Safety (QIPS) Plan at St. Mary's Medical Center (SMMC) is designed to ensure that Medical Staff, professional service staff, and all employees demonstrate a consistent endeavor to deliver high quality care in an environment of minimal risk. The culture supports innovation, data management, performance improvement, commitment to customer satisfaction, proactive risk assessment, and patient safety.

Mission Statement

We are inspired by the love of Christ to provide quality health care in ways which respect the God-given dignity of each person and the sacredness of human life.

Vision Statement

Our vision is to continue the healing ministry of Jesus Christ. We seek to fulfill this vision by:

- Making basic health care accessible and affordable to all, with special concern for the poor
- Providing high quality care, with measurable outcomes, in loving and compassionate ways that minister to the needs of the whole person (physical, psychological, and spiritual)
- Continuing to provide a full range of quality tertiary services to those we serve
- Providing health services that emphasize wellness, prevention and primary care, and the responsibility of individuals and families for maintaining their own health
- Selecting partners who share a common vision, and are committed to mutually respect of each other's values
- Continuously improving the quality of health care available in our community through strong support for educational programs in medicine and healthcare related fields; and for staff, patients and the community

Statement of Values

In our continuous pursuit of excellence we are guided by the following values:

- **C**ompassion: Sharing loving concern and understanding for the whole person
- **H**ospitality: A warm, helpful, and welcoming attitude toward all persons
- **R**everence: Respect for the God-given dignity of each person
- **I**nterdependence: Cooperation and collaboration among all members of our health and community
- **S**tewardship: Responsible use of and accountability for our human, material, and financial resources
- **T**rust: Integrity, truthfulness and straightforwardness in relationships

II. Fundamentals of Quality Improvement and Patient Safety

A. Key elements

Organizational performance that achieves and sustains high quality care and services is a complex, interdependent process. Key elements of the success of this plan include the following:

- leadership that is competent, committed and stable
- reliable capital and operational funding sufficient to achieve the mission
- human resources – stable staff
- an inclusive process supported by all stakeholders
- selective, focused performance improvement initiatives

B. Limitations of the plan

Like all plans, this plan is an expression of intent that outlines a philosophy and a process for self-improvement. As such, this plan is intended to be flexible and to accommodate timely and appropriate adjustments to address seen and unforeseen circumstances, while adhering to the fundamental mission, vision and values of the medical center

III. Objectives

A. Provide a broad range of value-oriented quality health care services
B. Establish clear strategic direction relative to commitments to the community
C. Improve the safety and quality of care and services by measuring, assessing, and improving leadership, clinical and support processes
D. Shift the primary focus from the performance of individuals to the performance of the organization's systems and processes, while continuing to recognize the importance of individual competence
E. Utilize internal and external customer feedback to improve the services necessary to excel in a competitive health care environment
F. Organize data into useful information, including internal and external data sources
G. Utilize external information sources representing evidence-based or "Best Practices" in the design of systems to improve patient outcomes and processes
H. Utilize results from internal committees to improve processes and outcomes
I. Promote the provision of a comparable level of care throughout the medical center
J. Utilize results of the Quality Improvement and Patient Safety Plan in a continuing education program
K. Achieve improved outcomes that meet or exceed regulatory standards
L. Enhance communication of quality monitoring results between Medical Staff, Medical Center Departments/Services, and the Governing Board of Trustees

IV. Scope and Applicability

A. The scope of the Quality Improvement and Patient Safety Plan covers measurement and assessment activities of the medical staff, nursing, and ancillary/support services.
B. Quality improvement and patient safety activities address clinical, non-clinical, and organizational functions.

C. This plan applies to all medical center departments, care, treatment, and service settings (including those services furnished under contract or arrangement).

V. Authority and Responsibility

A. Quality improvement and patient safety is the responsibility of everyone employed by, on the medical staff of, or contracted with St. Mary's Medical Center.

B. The Board of Trustees (BOT) retains overall responsibility and accountability for the quality of patient care, including the safety of patients, staff and visitors and the appropriate utilization of resources.

C. SMMC recognizes the need for leadership driven systems that will assist the governing body, administration, hospital and medical staffs to set priorities to:

1. Establish a planned, systematic, and inter-professional approach to improving the care, treatment and services provided; and
2. Develop, implement, and maintain an effective, ongoing, organization-wide data-driven quality assessment and performance improvement program that fosters the journey towards becoming a high reliability organization (HRO)

VI. Organizational Structure

A. Governing Board of Trustees

1. Composition

   Board members include community leaders, hospital administrators, and physicians.

2. Responsibility

   The Board of Trustees shall review and evaluate patient care services to assess and improve the overall quality, safety and efficiency of patient care services. While maintaining overall authority, the Board delegates operational responsibility to the Medical Staff and Administration. The Governing Body authorized the Quality Subcommittee of the Board of Trustees to implement the Quality Improvement and Patient Safety Plan.

   To fulfill this obligation, the Governing Body will:

   - Receive, review, and act upon periodic reports of findings, conclusions, recommendations, actions, and results of quality monitoring activities
   - Assess the program's effectiveness and efficiency annually, and if necessary, require modification to organizational structure and systems to improve outcomes
   - Provide the resources and support systems needed for quality improvement functions
   - Require a process designed to assure that all individuals responsible for the provision of care and services are competent

B. Quality Subcommittee of the Board of Trustees

1. Composition

Quality subcommittee members include President-Elect of the Medical Staff, Chair of the Credentials Committee, select members of the Board of Trustees, and hospital administrators.

2. Responsibility

The Quality Subcommittee of the Board of Trustees oversees, coordinates, and directs quality improvement and patient safety activities. The purpose of the subcommittee is to integrate all medical center activities designed to improve the quality of patient care.

To fulfill this obligation, the Quality Subcommittee will:

- Review and analyze relative outcomes and process data, with subsequent recommendations for specific actions or projects to address key quality improvement and patient safety issues.
- Charter performance improvement team(s), or delegate authority for multi-disciplinary teams to analyze undesirable patterns and trends
- Meet monthly and prepare reports of their activities for the Board of Trustees.
- Annually evaluate the Quality Improvement and Patient Safety Plan.

C. Medical Executive Committee (MEC)

1. Composition

The MEC consists of the President, President-Elect, and Secretary of the Medical Staff; chiefs of section; 3 active medical staff members; and ex-officio members.

2. Responsibility

The MEC oversees all medical staff-related issues with formal oversight of peer review concerns, physician effectiveness, and credentialing. The MEC must review and endorse recommendations clinical process improvement activities having a direct impact on patient care.

To fulfill this obligation, the MEC will:

- Define the executive power of the chiefs of section
- Formulate policies designed to maintain a standard of professional service and scientific work
- Standardize hospital procedures, when possible, to fully utilize the facility for study, diagnosis and treatment of patients
- Promote advancement of scientific medicine and research within the organization and supervision over all practices
- Coordinate activities and general policies of the various services, to act for the staff as a whole, to make recommendations to the Board of Trustees within the scope authorized by the Bylaws, and to act upon reports of committees, both standing and special
- Provide recommendations to the Board of Trustees on Medical Staff appointments, reappointments, delineation of privileges, service assignments, suspensions and corrective action, and on other matters related to overall medical care

- Recommend changes to the Rules and Regulations and policies of the Medical Staff, as well as urgent interim bylaw changes

D. Committees (see next section)

E. Administration

Senior Leadership of SMMC led by the Chief Executive Officer, assumes responsibility for the quality and safety of patient care and services performed by non-physician professional and technical staff.

To fulfill this obligation, Senior Leadership:

- Provide adequate staff and resources to carry out the quality review functions
- Establish and maintain operational linkages between risk management functions and quality improvement functions
- Promote collaborative monitoring and evaluation of patient outcomes and key functions through various committees
- Participate in the analysis of appropriately addressing identified problems
- Evaluate the performance of all clinically contracted services in collaboration with the respective department director and associated medical staff, reporting the results to the Quality Subcommittee of the Board of Trustees

F. Department Directors and Managers

Department Directors are accountable to Administration and the Governing Body for the quality and safety of care/services and performance of staff within their respective departments.

Department Managers are responsible to set expectations and manage the processes that continuously measure, analyze and improve activities within their departments and support quality improvement teams. Quality improvement activities that do not require a large cross functional team are the responsibility of the managers of departments involved in the improvement effort.

G. Role of Employees

The role of the individual employee is critical to the success of quality improvement initiatives. St. Mary's Medical Center believes quality is everyone's responsibility. All employees should believe that any process can be improved and feel empowered to contribute to prevention and improvement efforts, and report without fear of blame or retaliation.

VII. Committee Structure

A. Credentials Committee

Responsible for the oversight and review of all Medical staff applicants, investigation of ethical breaches, review of records referred from various committees regarding practitioner competence, and as such review, making recommendations for the granting of privileges, reappointments, and the assignment of members to medical staff sections.

B. Quality Performance Monitoring Committee
Responsible for the monitoring and evaluation of the quality of patient care provided by individuals with delineated clinical privileges, review and oversight of the peer review process, and variances from rules, regulations, policies and/or protocols by the organized medical staff.

C. Infection Prevention Committee
Responsible for risk reduction of disease transmission in the health care environment by using sound epidemiological principles and the establishment of a plan of action to prevent disease transmission when possible, monitor its occurrence, and initiate measures to minimize the impact in those cases that cannot be prevented.

D. Risk Management and Corporate Compliance Committee
Responsible for the monitoring of efforts that reduce actual or potential identified risks. Responsible for the investigation and analyses of the cause and frequency of general categories/types of risk events, that result in actual or potential adverse outcomes to patients, visitors, and staff. Provides oversight for potential and actual legal matters, as well as monitors ethical and moral business practices.

E. Resource Utilization Committee
Responsible for the appropriate allocation of medical center resources by providing quality patient care in the most cost effective manner. The committee provides for timely review of the medical necessity for admission, continued stays and services rendered, in addition to overutilization, underutilization and inefficient scheduling of resources and denials of service from external agencies.

F. Pharmacy and Therapeutics Committee
Responsible for adopting or assisting in the formulation of broad professional policies regarding evaluation, selection, procurement, distribution, use safe practices and other matters pertinent to drugs in the medical center. This committee shall serve in an advisory capacity to the medical center and medical staff, in all matters pertaining to the use of medications.

G. Environment of Care Committee
Responsible for the management and surveillance of safety and security activities to provide a safe environment that reduces the risk of injury through ongoing evaluation of the physical environment. The environment of care is made of three basic elements: building or space, including how it is arranged and special features to protect patients, staff and visitors; equipment used to support patient care and its safe operation; and minimizing risk to the people who enter the environment.

H. Emergency Management Committee

Responsible for providing a program that ensures effective mitigation, preparation, response and recovery to disasters or emergencies affecting the environment of care. The committee will develop an "all hazards" approach that supports a level of preparedness sufficient to address a wide range of emergencies/disasters regardless of the cause.

I. Regulatory Readiness Committee
Responsible for facilitating a continuous survey readiness program that incorporates both clinical and ancillary departments. The committee is responsible for survey preparation, including assigned accountabilities for departments and/or function leaders. The committee reviews standard development or revisions, provides reports on survey readiness, and assists departments to develop indicators to measure standard compliance.

J. Information Technology Steering Committee
Responsible for the effective use of electronic information and technology to support its dynamic use. Responsible for improving the information technology experience by increasing the access and usability of high-quality electronic health information and services.

K. Service Excellence Steering Committee
Responsible for enhancing the patient and family experience of care throughout St. Mary's Medical Center. The committee identifies nationally and internally defined best practices designed to improve the perception of service quality for patients and their support system.

L. Service Lines
Service lines focus on activities that have business and service interests in common. Each service line has a set of administrative and quality metrics by which their success is measured and reported on scorecards. Service line leaders therefore take responsibility for the quality, safety, and service provided.

M. Ad hoc Subcommittees or Teams
Responsible for the review of specific processes or systems within the medical center for improvement opportunities, as requested by a standing committee or other medical center leadership.

VIII. Framework for Quality Improvement and Patient Safety Activities

The organization's ongoing collection and monitoring program covers a multitude of variables including clinical, financial, operational, as well as patient and staff satisfaction.

Data collection activities will be based on priorities set by the organization's leaders, considering the populations served. Requirements for data collection imposed by funding sources and legal/regulatory agencies will also be included, when appropriate.

The data collected will be used to monitor the stability of existing processes, identify opportunities for improvement, and/or demonstrate sustained improvement.

IX. Strategic Initiatives

A. Service
- Achieve 78.9 score for HCAHPS category: rate the hospital 0 – 10
- Achieve service goal score based on area of responsibility. If department has an individual score, goal is based on top 30% performers

B. Quality
- CLABSI's - < 13 house-wide per year
- CAUTI's - < 17 house-wide per year
- C-diff - < 84 house-wide per year
- SSI for colon surgery - < 6 per year

C. Growth and Finance
- Net income from operations – 2.0%
- Total expenses as a % of revenue – 98%
- Total salaries as a % of revenue – 34%
- Supply expense as a % of revenue – 22.6%

D. People
- Hospital-wide turnover: 10% or less
- Visionware: 100% productivity

X. Collecting Data on Performance

A. Scope of Data Collection

At a minimum, the organization will collect data in the following areas:
- Performance improvement priorities identified by leaders
- Operative or other procedures that place patients at risk of disability or death
- All significant discrepancies between pre- and postoperative diagnoses, including pathologic diagnoses
- Adverse patient events
- Adverse events related to using moderate or deep sedation or anesthesia
- The use of blood and blood components
- All reported and confirmed transfusion reactions
- The results of resuscitation
- Behavior management and treatment
- Significant medication errors
- Significant adverse drug reactions
- Patient perception of the safety and quality of care, treatment, and services
- Patient thermal injuries that occur during magnetic resonance imaging exams
- Radiation dose index ranges for imaging protocols
- Events where ferromagnetic objects unintentionally entered the MRI scanner room

- Injuries resulting from the presence of ferromagnetic objects in the MRI scanner room
- Pain assessment and management
- Use of opioids, including safety and efficacy
- Processes that improve patient outcomes
- Prevention and reduction of medical errors
- Processes as defined in the organizations Infection Prevention Program, Environment of Care Program, and Patient Safety Program
- TJC ORYX and Accountability Measures
- TJC DSC Measures
- CMS IPPS, IQR, OQR, and IPFQR Measures
- NHSN Measures
- Meaningful use initiatives
- Conversion rate supplied from the Organ Procurement Organization

In addition, the following may be collected:

- State and regional collaborative measures
- Appropriate state and national service line registries
- Culture of Safety Survey
- Employee Opinion Survey
- Premier Quest and Partnership for Patients collaborative

Measurement of the above areas may be organization-wide in scope, targeted to specific areas, departments and services, or focused on select populations

B. Frequency of Data Collection

By approval of this program, the Governing Body has defined the frequencies of data collection to be ongoing, time limited, episodic, intensive, or recurring. The duration, intensity, and frequency of data collection to measure a specific indicator shall be based on the needs of the organization, external requirements, and the result of data analysis.

C. Detail of Data Collection

By approval of this program, the Governing Body has determined that data shall be collected in sufficient detail to provide the user of that data with sufficient information to make timely, accurate, and data-driven decisions.

XI. Aggregation and Analysis of Data

A. Purpose

The purpose of data aggregation and analysis is to:

- Establish a baseline level of performance
- Determine the stability of a process
- Determine the effectiveness of a process or desirability of an outcome to internal or external targets (benchmarks)
- Identify opportunities for improvement

- Identify the need for more focused data collection
- Determine whether improvement has been achieved and/or sustained

B. Construct

Performance measures should have a construct to assure that data is appropriately identified, collected, aggregated, displayed, and analyzed. In general, the construct should consist of:

- A definition of the measure
- The population to be measured (including, when appropriate, criteria for inclusion and/or exclusion)
- The type of measurement (i.e. rate based or event based)
- If rate based, a calculation formula (i.e. numerator/denominator)
- The minimum sampling size (where appropriate) to assure statistical validity
- The frequency of data collection / aggregation
- The methodology by which data will be collected
- The entity or party primarily responsible for data collection
- The manner in which aggregated data will be displayed
- The entity(s) to which the aggregated data will be reported to for analysis and action

C. Compilation of Data

- Data shall be complied in a manner that is usable to those individuals and entities charged both with analyzing the data, and taking action on the information derived from data analysis
- Where appropriate, statistical tools and techniques shall be used in data display, to assist in appropriate analysis

D. Analysis of Data

Data on performance measures will be analyzed to:

- Monitor the effectiveness and safety of services and quality of care
- Identify opportunities for improvement and changes that will lead to improvement

E. Analysis of Aggregated Data

Data on rate based performance measures are aggregated to determine patters, trends, and variation (common or special cause). Data may be aggregated from a single point in time or over time, depending on the needs of the organization and reason for monitoring performance. In general, measurement designed to establish the desired stability of a process or a desired outcome will be measured over time until target levels of performance are met or the process no longer exists.

Once a process is considered stable, and/or a desired level of performance has been achieved, then an analysis of performance measures may be conducted in a more episodic fashion.

Data that is event based is analyzed in singular or aggregated form depending on the number of data elements in the performance measure. In general, event based measurements are monitored on an ongoing basis.

Where appropriate, data shall be compared against internal and/or external benchmarks to allow comparative performance over time.

F. Intensive Assessments

Data will be intensively assessed when the organization detects or suspects undesirable performance or variation. Intensive analysis is called for when:

- Levels of performance, patterns, or trends vary significantly and undesirably from those expected
- Performance varies significantly and undesirably from that of other organizations or recognized standards
- A patient safety event, such as a sentinel event, has occurred (root cause analysis)

XII. Improving Quality and Patient Safety

A. Performance Model

The organization will take efforts to improve existing processes and outcomes and then sustain the improved performance. To accomplish this, the organization has adopted the FOCUS-PDCA performance improvement and change model, as well as high level tools of Lean and Six Sigma. The performance improvement model is utilized – formally and informally – in improvement efforts throughout the organization.

FOCUS – PDCA is a simplified approach to standardizing performance improvement, and is very appropriate for basic improvement initiatives. Many of the tools used in FOCUS – PDCA are also contained in the Six Sigma "toolkit".

- **F**ind a process to improve
- **O**rganize an effort for improvement
- **C**larify current knowledge of the process
- **U**nderstand reasons for variation within the process, and measure the process
- **S** elect a strategy for improvement based on the **C**larified knowledge and **U**nderstood variations
- **P**lan the improvement
- **D**o the testing of the action
- **C**heck to determine the effect of the action
- **A**ct on implementing the action on a wide scale

Six Sigma (DMAIC) is a methodology of systematically driving out waste by improving activities, connections, and workflows. It is a concept of reducing error and deviation from expected results, and provides a toolkit that helps identify elements such as errors, delays, and the cost of poor quality.

- **D**efine the problem
- **M**easure the outcomes

- Analyze the inputs
- Improve the process
- Control to validate changes are still in place, and that improvements are recognized and sustained

Lean is a set of tools established to evaluate the expenditure of resources for any goal other than the creation of value for the end user to be wasteful, and thus a target for elimination. Examples of Lean tools are:

- Rapid Kaizen Project (RIP) – a way of managing projects where resources are allocated so that the majority of the work of a project is done within a one to two week period, including design, implementation, and follow-up planning
- Value stream mapping – detailed documentation of processes in flowchart form, with consideration of external factors and process variations
- Waste identification – an intentional review of work to assess for the 8 specific types of waste that can occur in healthcare
- 5S – organizing the work environment to be effective and efficient
- Standard work – detailed documentation that addresses common situations and the "standardized" actions and responses

B. Prioritizing Quality Improvement Activities

The organization will prioritize those performance improvement activities that are system-wide and entity specific that address processes that:

- Focus on high-risk, high-volume, or problem prone areas
- Consider the incidence, prevalence, and severity of problems in those areas
- Affect health outcomes, patient safety, and quality of care

C. Quality Improvement Projects

As part of its quality assessment and performance improvement program, the organization must conduct performance improvement projects.

- The number and scope of distinct improvement projects conducted annually shall be proportional to the scope and complexity of the hospital's services and operations
- The organization shall document what quality improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects
- At least every 18 months, one high-risk process and conducts a proactive risk assessment

D. Improving Quality and Patient Safety

- Quality improvement activities shall, at minimum, track medical errors and adverse patient events, analyze their causes, and implement preventative actions and mechanisms that include feedback and learning throughout
- The organization shall take action aimed at performance improvement and after implementing those actions; the organization shall measure its success, and track performance to ensure that improvements are sustained

- Action shall also be taken when planned improvements are not achieved or sustained

E. Reporting of Quality Improvement Activities
Regular reports on the status and effectiveness of quality improvement activities shall be made to the Governing Body as well as the leadership of the organization and its medical staff

XIII. Education

Educational needs for quality assessment, measurement, improvement, and patient safety activities will be identified by the various teams, committees and subcommittees and will be incorporated into the organization wide training calendar and in other settings as designated by the leaders of the organization.

XIV. Communication

A. Communication of quality improvement/patient safety activities throughout the Medical and Hospital Staffs occurs through a variety of means that includes, but is not limited to the: Board of Trustees; Quality Subcommittee of the Board of Trustees; administration; medical staff and medical center committees and staff meetings; educational offerings; intranet; electronic mode, newsletters and memos.

B. A quality/patient safety report is communicated to the Board of Trustees and the Quality Subcommittee of the Board of Trustees. Content of the quality reports varies per the established entity calendars. The Quality Subcommittee may delegate that department specific performance improvement activities be reported to the appropriate medical staff and other committees/areas that will promote the implementation of improved patient care.

XV. Confidentiality Statement/Conflict of Interest

The quality/performance improvement plan is developed under the auspices of the board of trustees, medical staff, and administration to design, assess, measure, and improve patient care and organizational functions rendered by the medical staff and medical center personnel. Physician peer review data will be provided to executive officers of the medical staff and chairpersons of the physician peer review and credentialing committee. As such, all proceedings are confidential. Reports, minutes and other findings may not be released to or discussed with any person or agency except those mandated by hospital policies and congruent with State or Federal laws.

XVI. Annual Assessment

The leaders of the organization annually assess their participation in the performance improvement/patient safety process to identify opportunities to improve the overall process and leadership of the programs.

Reviewed January 1987

Revised January, 1988

Revised January 1989

Revised October, 1990

Revised January, 1992

Revised January, 1993

Revised January, 1994

Reviewed January , 1995

Reviewed January, 1996

Revised March, 1997

Reviewed March, 1998

Revised April, 1999

Revised February, 2000

Revised April, 2001

Revised October, 2002

Reviewed November, 2003

Revised July, 2004

Revised September, 2004

Revised October, 2005

Reviewed February, 2006

Revised December, 2007

Reviewed January, 2008

Revised February, 2009

Revised December, 2009

Revised February, 2010

Revised February, 2011

Revised February, 2012

Revised October, 2013

Revised November, 2014

Revised October, 2015

Revised October, 2016

Reviewed January, 2017

Revised May, 2018

Revised May, 2019

Patient Rights

ST. MARY'S MEDICAL CENTER
POLICY AND PROCEDURE MANUAL

Title:	Patient Rights	Type:	Medical Center Operations Manual
Section:	Organizational Ethics/Mission Integration	Prepared By:	Ethics Committee
Approved By:	Policy & Procedure Committee	# of Pages:	5

Policy: St. Mary's Medical Center is committed to respecting the rights of all who entrust their care to us. To effectively carry out the mission, values and philosophy inherent in the medical-moral teachings of the Catholic Church as outlined in the *Ethical and Religious Directives for Catholic Health Care Services*, the Medical Center respects, protects and promotes each patient's right to be treated in a dignified and respectful manner that supports his/her dignity as a child of God. In keeping with the *Ethical and Religious Directives* abortions, sterilization, euthanasia and physician assisted suicide are not permitted in this facility. The patient is to be informed of his/her rights prior to furnishing or discontinuing care whenever possible. The Medical Center is to inform patients that they also have corresponding responsibilities, that include, but are not limited to, providing necessary information related to their conditions that will allow health care providers to deliver optimal care to them.

B. PATIENT RIGHTS:

Patients have the right to:

1. reasonable access to care;
2. considerate care, provided by competent staff, that safeguards their personal dignity and respects their cultural, psychosocial and spiritual values, as these impact their care;
3. the optimal level of pain relief that can be safely given; To be believed when they say they have pain;
    - To receive pain medication on a timely basis
    - To information about pain and pain relief measures, risks and benefits
    - To a concerned staff committed to pain prevention and management:
4. know by name the physicians responsible for their primary care and to be involved in all aspects of their care;
5. obtain from their physicians current information concerning their diagnosis, treatment;
6. receive information through verbal and written communication in a manner tailored to their age, language and ability to understand;
7. participate in care decisions, and not be subjected to any procedure without their voluntary, competent and informed consent. If they lack decision-making capacity the consent of their designated surrogate decision-maker is required;

8. receive from their physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include, but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of recovery time. When different treatment options exist, the patient have the right to be told what these options are and the risks involved in choosing the options;
9. put into writing advance medical directives and appoint a representative to make healthcare decisions on their behalf when they are no longer able to make them themselves;
10. refuse treatment to the extent permitted by law, and to be informed of the medical consequences of such refusal;
11. request a second opinion or consultation with a specialist;
12. request a transfer to another room if another patient or visitor is unreasonably disturbing him/her;
13. request help from the hospital's Patient Advocate or the Ethics Committee should differences arise between them and their physicians, the hospital staff and/or members of their family, in regard to treatment options or other issues. This help may be requested through the physician, a nurse, Social Services or Pastoral Care staff members. The number of the Patient Advocate is 304-526-6013.
14. lodge a complaint with the appropriate state regulatory system where the healthcare was provided, whether or not they have first used the Medical Center's process to resolve the complaint;
    - *If care was provided at St. Mary's Medical Center in West Virginia, the contact agency is the WV Department of Health and Human Resources at 304-558-0050.*
    - *If care was provided at St. Mary's Medical Center Ironton Campus, the contact agency is the Ohio Department of Health Division of Quality Assurance at 800-342-0553;*
15. be treated with respect and dignity when dying. Goals of care are to be consistent with patients' advance directives or known wishes and directed to keeping them as comfortable and pain free as possible;
16 expect that every consideration be given to safeguard their privacy concerning their medical care/condition. Consultations, examinations and treatments are confidential and will be conducted discreetly. Those not directly involved in the care must have the permission of the patient to be present;
17. expect that all communications and records pertaining to their care will be treated as confidential. Their medical records will be reviewed only by individuals directly involved with the care or monitoring of its quality, or others authorized by them in writing for legal purposes;
18. refuse to talk to or see anyone not directly involved with their care, including visitors;
19. be placed in protective privacy when considered necessary for personal safety and have the right to access protective services;
20. expect that patients treated in the hospital will receive the most appropriate care within the scope of services available at this hospital. If it is determined that the patient needs services not available at this hospital arrangements will be made to

transfer the patient to an appropriate facility which provides the needed services. Transfer to another facility may also occur at the request of the patient or of the family, if the patient lacks decision-making capacity for him or herself. Prior to the transfer, consent will be obtained from the patient or surrogate decision- maker. The health care facility to which the patient is to be transferred must first agree to accept the patient before the transfer is made;

21. have access to information as to the relationship of St. Mary's Medical Center to other health care and educational organizations insofar as their care is affected. Patients have the right to know what, if any, professional/ business relationships exist among individuals who are treating them;
22. be advised if their physician proposes to use any type of experimental treatment procedure or medication on them. The physician is to explain the potential risks and benefits of the proposed treatment. Patients' informed consent is required before any such treatment can be started. Patients also have the right to refuse to participate in these research projects and their refusal will not compromise their access to services;
23. be informed of the Medical Center's rules and regulations that apply to their conduct as patients;
24. have access to people outside the hospital by means of visitors and by verbal and written communication; the right to receive visitors they designate, including but not limited to, a spouse, a domestic partner, including a same sex partner, another family member or a friend. The patient also has the right to withdraw or deny such consent at any time. Visitation may be restricted, for protection of the patient or visitors, based on clinical necessity. If unable to communicate in English, or are hearing or sight impaired, patients shall have access to interpreters and/or mechanical equipment when possible;
25. expect reasonable safety within the practices and environment of the Medical Center.
26. see that corrective action is taken if indicated when, in their opinion their rights are not being respected;
27. expect reasonable continuity of care and to be informed of the need for any follow-up care after discharge by their physicians or delegates, including details of what, when, where and how to get the needed follow-up care;
28. examine and receive an explanation of their bill regardless of the source of payment.
29. expect that clinical decisions about their care will be based on medical necessity and will not be affected by financial incentives or ability to pay and that they may contact the Financial Counselor or the Corporate Compliance Officer if they feel that the care provided to them was negatively affected by the Medical Center's financial relationship to a care provider;
30. be free from physical or mental abuse, and corporal punishment;
31. be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

Quality or safety issues not resolved to the patient's satisfaction at the hospital level may be directed to The Joint Commission (TJC) at 1-800-994-6610.

PATIENT RESPONSIBILITY

Patients also have responsibilities to the hospital and their physician. The hospital has the right to expect patients to:

1. provide accurate and complete information about their past and present health status and hospitalizations; report changes in their conditions; and to question any actions or orders that they do not understand;
2. follow the treatment plans prepared, in consultation with them, by their physicians and nurses;
3. be responsible for their actions and the results if they refuse treatment or do not follow caregivers' instructions;
4. follow hospital rules and regulations affecting their care and conduct;
5. follow the no-smoking rule which states that patients and visitors will not smoke on the Medical Center's property;
6. be considerate of other patients and hospital personnel; respect the property of other patients and the hospital; and to assist with the control of their visitors;
7. provide accurate and complete information concerning their next of kin and medical power of attorney, their financial situation and to be responsible for their financial obligations;
8. make known to the Patient Advocate or nursing, either by telephone or letter, any concerns regarding the services received from the hospital. The Patient Advocate's phone # is 304-526-6013 or 800-978-6279, ext. 6013

A copy of the "Patients' Rights" is in the Patient Information folder each patient receives at time of admission and copies are available in outpatient admission areas.

C. SMMC requires adherence to the *Ethical and Religious Directives for Catholic Health Services* as a matter of policy.

The purpose of Catholic health care services is to continue the healing ministry of Jesus, to promote Christian community and to enhance the dignity of all by providing optimal health care services and programs to those being served. This hospital recognizes the inherent rights of patients or their representative to receive appropriate information to permit them to make judgments regarding their care. The patients/representatives should understand that the nature, content and scope of the information supplied by their physicians rest in the sound professional judgment and discretion of their physicians.

D. Spiritual, Cultural and Psychosocial Values

1. In keeping with its philosophy, and state and federal laws the Medical Center will recognize the psychosocial, religious, spiritual and cultural values of each patient admitted to the Medical Center. These needs will be met as long as they do not interfere with the well-being of others or with the medical care of the patients.

2. Patients' religious affiliation will be requested at the time of admission so that staff will be able to contact the appropriate pastor upon request from the patient or family. Pastors, priests, and rabbis will have access to their parishioners at any time except during treatments and procedures or when the patient requests "no publicity" or "no visitation".

3. Caretakers will consider the spiritual, religious, cultural and psychosocial needs of all patients and their families especially those who are dying.

4. Chaplains are available 24 hours a day to provide spiritual and emotional support for patients and their families as needed and should be called anytime death is imminent. The patient's pastor will be called at the request of the patient/family. Chaplains are also available to assist families through the grieving process. (See section on Pastoral Care under CARE of PATIENTS.)

5. Staff should become aware of patients' cultural practices and religious beliefs and respect them to the extent possible. These practices should not interfere with quality health care nor should they be disturbing to other patients. In this area, attention should be paid particularly to Christian, Jewish, Hindu and Muslim faiths. Jehovah Witness's beliefs regarding blood and blood products should be noted in the medical record.

6. Patients' special needs related to religious beliefs or cultural practices can be met by involving other services in the Medical Center: for dietary restrictions contact Food Services; areas for prayer are available in the prayer room on 2 South or the chapel on 1 East; psychosocial needs can be referred to Behavioral Health, Social Service and Pastoral Care. Other needs will be met as required.

E. Research and Human Experimentation

Patients have the right to participate, or not to participate in research, investigational studies and clinical trials. The Medical Center is guided by the ethical principles regarding all research involving humans as set forth in the "Ethical Principles and Guidelines for the Protection of Human Subjects on Research" by federal regulations and the *Ethical and Religious Directives for Catholic Health Care Services*. Investigational studies require the prior approval of the HRPP and IRB and the informed consent of all patients involved in the study.

Formed: 4/19/77
Reviewed: 1984; 11/29/2005; 7/2008
Revised: 1981; 1987; 1990; 1992; 1993; 1994; 1996; 3/14/1997; 9/27/2002; 02/01/07, 2/08; 7/15; 11/2018

SECTION J: ANALYSIS OF COMPETITIVE FACTORS

1. **For each service being proposed or affected by this project, respond to the following.**

   a. **Describe the impact the proposal may have upon the utilization and operation of similar services offered by existing providers in the service area.**

   This is an existing multi-specialty physician practice. Therefore, the proposed acquisition is not expected to impact other physician practices in the service area.

   b. **Describe the potential impact the proposal will have upon the cost of available services to consumers in the area; provide a comparison of charges for similar services in the proposed service area.**

   There should be no impact on the cost of services. St. Mary's will use HIMG's fee schedule initially and transition to St. Mary's fee schedule

   c. **Describe the impact the proposal will have upon the quality of such health service(s) in the area.**

   The acquisition will allow for the continuation of the multi-specialty physician services provided by HIMG.

SECTION K: RELATIONSHIP TO LICENSURE, CERTIFICATION, ACCREDITATION AND SAFETY STANDARDS

1. **Describe the extent to which the proposal will be developed and implemented in accordance with state licensure, Medicare/Medicaid certification, accreditation, and fire and life safety code standards and other federal, state and local inspection agencies.**

   St. Mary's will comply with applicable certification, accreditation, fire and life safety, and any other federal, state, and local inspection agency requirements, as it does with its existing services.

2. **If the proposal serves to correct cited deficiencies in any of the aforementioned standards, explain. Attach copies of prior citations and/or statement of deficiencies and plan of correction.**

   Not applicable.

SECTION L: AVAILABILITY OF NEEDED RESOURCES

1. Proposed Plan for Financing

Complete applicable items and describe source, type, amount, rate, etc. Attach documentation, letters of commitment, additional information as pertinent.

	Type of Financing (check appropriate blanks)		Total Amount
	Lease		$
	Land ___ Building ___ Equipment ___ Fair Market Value $_____		
X	Cash Source: Cash on Hand		$10,550,000
	Conventional		$
	Principal	$	
	Interest	$	
	Term		
	Bonds		$
	Principal	$	
	Interest	$	
	Term		
	Debt Service Reserve	$	
	Gifts		$
	Grants		$
	Land Equity		$
	Other Owner Equity		$
	Notes	$	
	Stock	$	
	Other	$	
TOTAL FINANCING			**$10,550,000**

2. Complete this schedule of staff required for the services affected by this project.

See Exhibit L-1. Since this practice is being acquired by St. Mary's the current staff for St. Mary's for HIMG is zero.

JOB CLASSIFICATIONS	CURRENT FTEs	PROPOSED FTEs
Total		

3. **Present evidence of the availability of staff, including the medical staff, for the proposed project. Commitments or tentative commitments from prospective employees should be attached, if available.**

   All practitioners and staff are employees of the existing practice.

4. **If any facility-based personnel are to be provided through contractual arrangements, give the name of the secured or potential sources(s) and the services to be provided. Attach a copy of a contract, draft contract, or letter of commitment from each source, if available.**

   No applicable.

Staff Schedule

Department2	FTEs	Job Class
Audiologist	4	Aud D
Cardiology MLP	3	MLP
Cardiology	3	MD/DO
Electrophysiology MLP	2	MLP
Electrophysiology	1	MD/DO
Dermatology	1	MD/DO
Endocrinology MLP	1	MLP
Endocrinology	1	MD/DO
ENT	2	MD/DO
ENT MLP	1	MLP
Gastroenterology	5	MD/DO
Primary Care (IM)	3	MD/DO
Primary Care (FP)	9	MD/DO
Primary Care MLP	9	MLP
Nephrology	1	MD/DO
Neurology MLP	1	MLP
Neurologist	2	MD/DO
Hematology/Onccology	4	MD/DO
Opthalmologist	1	MD/DO
Optometrist	1	OD
Pain Management	1	MD/DO
Dietician	1	RD
Pharmacist	1.75	Pharm D
Plastic & Reconstructive Surgery	1	MD/DO
Podiatrist	2	DPM
Psychologist	1	Psych D
Occupational Therapist	1	OT
Physical Therapist	3	PT
Pulmonary MLP	3	MLP
Pulmonary/Critical Care	3.5	MD/DO
Rheumatology	1	MD/DO
General Surgery MLP	1	MLP
General Surgery	1	MD/DO
Urology	1	MD/DO
Total Practitioners	**77.25**	

HIMG Staff	FTEs
Accountant	1
Audiology Assistant	0.25
Audiology Billing	1
BRD Associate	3
Breast Center Specialist	0.5
Business Resolution Associate	1
Call Center Associate	9
CBO Float	2
CBO Manager	1
CEO	1
Charge Entry Clerk	7
Charge Entry Supervisor	1
Clinical Resources Coordinator	1
CMA	11
CMA/Secretary	1
CNA/CMA	2
Coding	1
Communinations Assistant Manager	1
Concierge	1
Cosmetic Coordinator	1
Credentialing Coordinator	1
CT Tech	3
Director, Grounds & Maintenance	1
Director, IS	1
Echo Sonographer	1
Echo Tech	1
EMG Tech	1
Endo Tech	1
Executive Assistant	1
Fax Clerk	2
Front Desk/Office Specialist	2
Histology Tech	1
HR Assistant/Credentialing	1
HR Coordinator	1
Intern	1
IS Administrator	1
IS Helpdesk	1
Lab Assistant	1
Lab Manager	1
Lab Registration Clerk	1
Lab Tech	2
LPN	21.5
Maintenance	1
Maintenance Tech	1
Mammography Tech	2.25
Medical Assistant	24
Medical Lab Tech	1
Medical Scribe	1
Medical Tech	3
Nuclear Medical Tech	2.75

HIMG Staff	FTEs
Ophthalomology Tech	4.5
Optician	2
Optometric Tech	1
Payment Posting Clerk	7
Payment Posting Supervisor	1
Payroll Coordinator	1
PC Manager	1
PFT Tech	2
Pharmacy Tech	4
Phlebotomist	7.5
Practice Manager	1
Pre Cert Billing Secretary	1
Pre Cert Clerk	6
Pre Cert Medical Auth	1
Pre Collect Scheduling Associate	2
PTA	3
Purchasing clerk	1
Quality Care Support	1
Radiology Tech	1
Receptionist	1
Registration Clerk	19
Registration Manager	1
Reimbursement Clerk	14.5
Reimbursement Clerk/reigistration	1
Reimbursement Supervisor	1
RN	27.75
Scribe	0.5
Secretary	40.25
Senior Accountant	1
Sleep Tech	1
Specialty Billing Clerk	0.5
Specialty Manager	1
Sterilization Tech	1
Stress Tech	1
Supervisor Cardiology	1
Surgical Tech	1
Systems Analyst	1
Transcription Manager	0.5
Transcriptionist	1
Ultrasound Tech	2
Urodynamic Tech	1
Vascular Ultrasound Tech	2
X-Ray Tech	4.75
Total	**304**

Note: Part-time staff estimated at 0.5 FTE;
Per diem staff estimated at 0.25 FTE.

SECTION M: POLICIES REGARDING STAFF EMPLOYMENT AND MEDICAL STAFF MEMBERSHIP

1. **Provide copies of existing or proposed policies for training and employment of facility staff.**

   As noted in its policy on Employment/Selection Process included as Exhibit M-1, St. Mary's "prohibits discrimination in employment based on race, religion, color, sex, age national origin, handicap, disability or veteran status." Recruitment and selection of employees shall be on their qualifications for a given position.

2. **Describe the facility's policies and procedures for medical staff membership, including the policy concerning granting staff privileges to allopathic and osteopathic physicians.**

   The appointment process of the Medical Staff is laid out in the Medical Staff Credentialing Policy and Procedure. A copy is included as Exhibit M-2.

3. **Describe existing or proposed in-service training programs to the types of employees who are associated with the proposal.**

   A copy of St. Mary's Orientation, Education & Training policy is included as Exhibit M-3. As stated in that policy, St. Mary's "will provide orientation, training and education to its staff in order for staff to fulfill their specified responsibilities."

Employment/Selection Process

ST. MARY'S MEDICAL CENTER

HUMAN RESOURCES POLICY MANUAL

Subject **EMPLOYMENT/SELECTION PROCESS**

Policy No. **E-7** **Department:** Human Resources

Prepared By: **CM/SBR** **Approved By:** HR Functional Team

Date Issued: **6/24/2016** **Previous Date:** 4/19/2016

PURPOSE: To provide for the appropriate selection and employment of individuals at St. Mary's Medical Center ("SMMC").

I. EMPLOYMENT

Recruitment and selection of employees shall be on the basis of their qualifications for a given position including ability, skill, experience, training, character, education, licensure/registration, and physical fitness to the degree required by the position as stated in the position description, performance requirements, and position specifications. SMMC prohibits discrimination in employment based upon race, religion, color, sex, age, national origin, handicap, disability or veteran status.

II. SELECTION PROCESS

A. It is the policy of St. Mary's Medical Center to recruit and select qualified and competent staff members whose qualifications are commensurate with position responsibilities and who possess applicable credentials if required of the position.

B. The Recruiter at SMMC in coordination with the nurse manager, office manager, coordinator, or administrator is normally responsible for interviewing and selecting candidates for employment.

C. The candidate must possess a high school diploma or GED at minimum to gain employment at SMMC.

III. EMPLOYMENT SELECTION GUIDELINES

1. Hiring Manager selects candidates for interview that meet all job qualifications.

2. The Hiring Manager will then schedule the applicants in for an initial interview to discuss position and qualifications. A peer interview maybe scheduled as well.

3. After selected the manager will forward the candidate or candidates that they have selected to Human Resources.

4. Human Resources will then schedule the applicant in for an interview and analyze the cultural fit and eligibility issues for the particular position. Once they have completed the Human Resources interview, the top candidates will receive a call from Human Resources and be made a conditional offer.

B. Making a Conditional Offer

1. If you decide to make a conditional offer of employment, you must:

2. SMMC Human Resources will make a conditional offer of employment to the top candidate, including pay and scheduling pre-employment appointments to complete paperwork in Human Resources to include health assessment and drug screen with SMMC Employee Health. HR will explain this is **NOT** an offer of employment.

3. Explain to the applicant that this is a **conditional** offer of employment. It is conditioned upon successful completion and passing of the SMMC Employee Health Assessment, drug screen and the criminal background check. This requires the applicant to complete a Health Assessment form detailing the applicant's medical history and to pass certain medical tests required of all new employees. The testing will include:

    a. TB Skin Test
    b. T. Spot and/or Chest X-Ray (for positive TB Skin Tests only)
    c. HBsAB
    d. Titers
    e. Rubella
    f. Rubeola
    g. Varicella
    h. Hepatitis panel

4. Explain that follow-up testing may be required where the assessment or medical tests indicate further testing is necessary.

5. Caution the applicant not to give notice to his/her current employer, sell any real estate, commit to any lease on local property or incur any other costs associated with changes in employment until **after** an official medical and c criminal background clearance has been received.

6. Reference checks are to be completed through Human Resources. Human Resources should obtain at least two, preferably three reference checks on those applicants that are going ~~thru~~ through the pre-employment process with the Medical Center. If there appears to be a reasonable doubt in the applicant's reference, it is recommended that the candidate not be employed.

Human Resources normally will not confirm employment until references are returned and completed.

a. Consent for background check is included in the application. The Recruiter will submit the application for criminal background check and will then be notified of those results via email. These results are normally available with 24-48 hours.

b. Drug testing is to be done during the pre-employment appointments and before the applicant leaves SMMC.

c. The "Notice of Drug Screen Results" will be used by the Employee Health Nurse to notify the Recruiter of those applicants who have successfully passed the employment drug screen.

d. If the applicant does **NOT** pass or **FAILS TO COMPLETE** the drug screen as scheduled, the Employee Health nurse will immediately notify the Recruiter. If the applicant inquires about the results of the drug screen, Human Resources will refer him/her to the Employee Health Nurse. Upon the request of the applicant, The Employee Health Nurse will schedule a meeting with the applicant to the discuss the result of the drug screen.

e. An individual may **NOT** begin work/employment unless medical clearance and criminal background clearance has been received.

C. Making Final Offer

Once all results are back satisfactorily, the Recruiter will make a final offer including start date to schedule in an Orientation.

Revised: June 11, 2001; November 7, 2000; December 8, 2000; March 4, 2002; February 13, 2012; January 13, 2015; April 19, 2016; **June 24, 2016**

Credentialing Policy and Procedure

ST. MARY'S MEDICAL CENTER
MEDICAL STAFF POLICY AND PROCEDURE MANUAL

Title:	Credentialing Policy and Procedure	Type:	Medical Staff Policy and Procedure Manual
Section:	Medical Staff	# of Pages:	17
Approved By:	Board of Trustees		

Policy: Credentialing Policy and Procedure The Credentialing Office conducts credentialing and privileging for all of the clinical sites within St. Mary's Medical Center (SMMC). Licensed Independent Practitioners and Allied Health Practitioners are credentialed in a strict and rigorous manner as outlined in this manual. These policies, procedures, and protocols have been developed to support the mission of the Credentialing Office.

Mission Statement

1. To provide credentialing services to Medical Staff and Allied Health Professionals (AHPs) in a professional and timely manner.
2. To provide accurate and appropriate information regarding the Medical Staff and AHPs to other departments within SMMC, the university and external entities, such as Health Plans.
3. To develop and maintain efficient methods for processing information pertaining to credentialing and privileging.
4. To strictly maintain confidentiality of protected information related to clinicians, patients and the institution.
5. To adhere to SMMC policies and procedures and the Bylaws of the Medical Staff.
6. To meet all legal, professional and accreditation requirements promulgated by public agencies and private organizations, including but not limited to: Federal and State regulations and Joint Commission.

Provider Scope

Credentialing is performed for all medical staff members (physician, podiatrist, psychologist, and dentists) and Allied Health Practitioners (Nurse Practitioners and Physician Assistants) practicing within SMMC.

1.0 Purpose:

To define the policies and procedures used in the appointment, reappointment, and credentialing of all licensed independent practitioners (physicians, podiatrists, and dentists) and Allied Health Practitioners who provide patient care services at St. Mary's Medical Center and other designated clinical facilities.

Procedure:
2.0 Scope

Credentialing and recredentialing is performed for physicians, podiatrists and dentists who practice at St. Mary's Medical Center and other designated clinical facilities. Other non-physician practitioners in professions allied to medicine may be credentialed for specific clinical privileges performed under the auspices or appropriate supervision of the medical staff. These practitioners shall be credentialed as either Physician Assistants (PA) or Advanced Practice Nurse Practitioners (APRN).

3.0 Initial Appointment

3.1 Conditions and Requirements for Appointment:

In order for a physician, podiatrist, dentist, or Allied Health Practitioner to be considered for appointment and clinical privileges at St. Mary's Medical Center, an applicant must meet all of the following criteria:

- Have a valid and unrestricted medical/podiatric/dental /allied health practitioner license to practice in the State of West Virginia and/or Ohio as applicable;
- Provide satisfactory evidence of appropriate training and education in the designated specialty;
- Hold current professional malpractice insurance at levels acceptable to St. Mary's Medical Center which currently is not less than $1,000,000 for each medical incident and not less than $3,000,000 as an annual aggregate; and
- Currently Board certified or an active candidate/board eligible candidate in the process of obtaining board certification who obtains initial board certification, no later than five (5) years from initial appointment to the Medical Staff. This requirement applies to providers appointed to St. Mary's Medical Center Medical Staff after September 2, 2008.

3.2 Nature of the Application:

Application for membership on the Medical Staff shall be presented in writing on the West Virginia state application with St. Mary's Medical Center's addendum, which has been signed by the applicant. Upon signing and dating the application, applicants:

- Attest to their qualifications to perform the clinical privileges requested;
- Signify that they have read the St. Mary's Medical Center Bylaws, Rules, Regulations, Policies and

Procedures of the Medical Staff and agree to be bound by their provisions;
- Agree to provide for continuous patient care;
- Attest that the application is accurate and complete and that the credentialing body will be promptly and fully informed of any and all changes;
- Signify their willingness to appear for the interviews in regard to their application;
- Adhere to St. Mary's Medical Center Policy and Procedures for compliance.

3.2.1 Preceptor/Proctor

A modified application for permission as a preceptor/proctor for a member of the Medical Staff shall be presented in writing which has been signed by the applicant. Upon signing and dating the application, applicants:

- Attest that privileges requested are for **observation only** and applicant will **not** be providing direct patient care. (If applicant desires patient care privileges, refer to full initial appointment section 3.1)
- Supply all information as outlined in section 3.5.2 and submit credentials to support the request for the specific privilege(s) to be proctored
- Signify that they have read the St. Mary's Medical Center Bylaws, Rules, Regulations, Policies and Procedures of the Medical Staff and agree to be bound by their provisions;
- Attest that the application is accurate and complete and that the credentialing body will be promptly and fully informed of any and all changes;
- Signify their willingness to appear for the interviews in regard to their application;
- Adhere to St. Mary's Medical Center Policies and Procedures for compliance.

3.3 Release:

In connection with the application, applicants agree to release from liability St. Mary's Medical Center, its employees, agents, Trustees, Medical Staff, and their representatives, for their acts performed in good faith and without malice, in connection with evaluating and making recommendations and decisions based upon their application, credentials, and qualifications for staff membership and clinical privileges. In addition, the applicant shall:

- Consent to inspection by St. Mary's Medical Center of all records and documents it may deem material to the evaluation of his/her qualifications and competence to carry out the privileges he/she is seeking, physical and mental health status, and professional and ethical qualifications;
- Release from any liability all authorized individuals and organizations who provide requested information to St. Mary's Medical Center or its representatives concerning his/her competence, professional ethics, character, physical and mental health, quality of care, and other qualifications for appointment and privileges; and
- Authorize and consent to St. Mary's Medical Center representatives providing other authorized organizations, including managed care organizations, surveyors, and auditors, information concerning his/her professional competence, ethics, character and other qualifications, only as necessary to complete accreditation, contracting, and/or utilization reviews or as otherwise required

by law. Such organizations will be required to hold the information as privileged and confidential and such information may not be further released or utilized in any other manner.

3.4 Continuing Duties of Applicants and Medical Staff Members:

It shall be a continuing duty on the part of all applicants and Medical Staff members to promptly update application information on an ongoing basis. This information shall include but not be limited to the following:

- Voluntary or involuntary termination of appointment, limitation or reduction, or loss of privileges at any hospital, healthcare organization, or managed care organization, or any restriction of practice or severance from employment by a medical practice;
- Any investigations, charges, limitations or revocation of professional license in the State of West Virginia and/or Ohio as applicable, or any other state;
- Any investigations, charges, limitations, or corrective action by any professional organization;
- Changes in physical or mental health which effect ability to practice medicine;
- Any investigations, convictions, arrests, or charges related to any crime (other than minor traffic violations), including crimes involving child abuse;
- Any "quality query" from any qualified peer review organization, or its equivalent;
- Any investigations regarding reimbursement or billing practices;
- Any professional investigations or sanctions including but not limited to Medicare or Medicaid sanctions;
    - Notification of cancellation or proposed cancellation of professional liability insurance and;
    - Disclosure and updates of malpractice claims or other actions initiated or made known subsequent to appointment. Information should contain case number, style of case (i.e., Joe Jones on Behalf of the Estate of Jennie Jones vs. John Doe, M. D., Paul Doctor, M. D., and St. Martin's General Hospital), county in which the case is filed, patient's name, nature and summary of the action, and the name, address, and telephone number of the practitioner's attorney.

3.5 Initial Application Process:

If the applicant meets the criteria described in the St. Mary's Medical Center Medical Staff Bylaws and Policies and Procedures, a credentialing application for membership and/or privileges shall be provided upon request to the physician or to the clinical service where the privileges will be exercised. In addition, the applicant will receive a copy of the St. Mary's Medical Center Medical Staff Bylaws, Rules and Regulations, and summaries of other hospital, clinic, and policies relating to clinical practice in the Medical Center.

3.5.1 Content of an Initial Application:

The initial application form shall include requests for:

- Information pertaining to professional licensure including a request for information regarding previously successful or currently pending challenges, if any, to any licensure or registration or the voluntary or involuntary relinquishment of same;
- DEA certification (if all six (6) schedules are not included, then written explanation of omission must be appended);
- Professional education, training, and experience;
- Information pertaining to malpractice coverage and claims history;
- Health status relative to ability to perform privileges requested;
- Provide evidence of TB screening within the past year, subject to the guidelines listed in Appendix A
- Information pertaining to hospital and practice affiliations including a request for information regarding voluntary or involuntary limitation, reduction, or loss or clinical privileges, or termination at any other healthcare institution or organization;
- Membership in professional societies;
- Peer recommendations;
- Practice history;
- Request for clinical privileges;
- Release form;
- Medicare/Champus Attestation Statement;
- Signed Principles of Collaboration;
- Signed Patient Safety Responsibility and Validation;
- Signed Statement of Understanding/Standards of Conduct;
- User Identification and Information Technology Access Agreement.

3.5.2 Responsibility of the Applicant:

It is the responsibility of the applicant to return a signed, dated, and fully completed application and request for clinical privileges with the following:

- Current copy of West Virginia and/or Ohio license and DEA certificate (with applicable State Address)with all six schedules or explanation of omission;
- Copies of certificates showing evidence of completion of education and training, if available;
- Copy of Board Certification certificate, if applicable;
- Copy of ECFMG certificate, if applicable;
- Current and dated curriculum vitae (month/year format) outlining education and practice history with written explanations of gaps greater than ninety (90) days;
- Copy of certificate evidencing professional liability insurance coverage; and
- Any additional information required in response to questions on the application form.

3.5.2.1 Applicant's Responsibility for Producing Information:

The applicant shall have the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics, ability to work with other professionals and nonprofessionals in the hospital, and other qualifications, and for resolving any doubts about such qualifications. The practitioner has the right to review any and all information that s(he) has provided in support of his/her application. Falsification of a Medical Staff application shall be grounds for denial of appointment or reappointment to the Medical Staff and/or termination of membership and clinical privileges.

3.5.2.2.1 The applicant has the right to review information submitted to support their credentialing,

3.5.2.2.2 The applicant has the right to correct erroneous information,

3.5.2.2.3 The applicant has the right, upon request, to be informed of the status of their credentialing application,

3.5.2.2.4 The applicant is notified of these rights by receiving these Policies and Procedures.

3.6 Verification Process:

Upon receipt of an application, Medical Staff Services will review the application for completion. If the application is incomplete, the physician will be notified in writing outlining the deficiencies in the submitted application. Medical Staff Services will begin the application processing procedure by verifying the information outlines below:

- Verification of West Virginia and/or Ohio license directly with the State Licensing Board, and other state licenses by receipt of information from either the appropriate State Licensing Board or the Federation of State Medical Boards;
- Verification of graduation from medical school, nursing school, physician assistant program etc. as appropriate for the staff type and clinical privileges requested;
- Verification of postgraduate professional training;
- Verification of board certification through the use of the American Medical Association, the Directory of the American Board of Medical Specialties, directly with the appropriate specialty board or via Internet, where applicable;
- Verification and status of past and current hospital affiliations;
- Group practice affiliations during the past seven years, if applicable;
- Current and past malpractice insurance information concerning coverage, claims, suits, and settlements during the past ten years from malpractice carriers;

- Information from the National Practitioner Data Bank;
- Evidence of Medicare/Medicaid Sanctions or investigations from both the Office of Inspector General and Excluded Parties Listing System websites;
- Three peer references who are able to provide information about the applicant's current clinical competence, relationship with colleagues, and conduct. References must be from individuals practicing in a field similar to the applicant who are not family members or current practice partners; and
- Any other relevant information requested from any person, organization, or society that has knowledge of the applicant's clinical ability, ethical character, and ability to work with others.

This information may be obtained either in writing or verbally. If the information is obtained verbally, the person making the verification shall document in the practitioner's file the date, the person he/she spoke with, the status of affiliation or licensure, issuance and expiration dates where applicable, and the information provided.

3.7 Inability to Obtain Information:

3.7.1 In the event that there is a delay in obtaining any required information outlined in §3.6, or if clarification of information is needed, the applicant will be notified and informed of his/her responsibility to obtain the necessary information. Failure of the applicant to adequately respond to a request for the required information within fifteen (15) days will result in discontinuance of the application process. The applicant shall be notified in writing, by certified mail that the application will be presented for withdrawal at the next regularly scheduled meeting of the Credentials Committee. This is an administrative action and shall not constitute an adverse action pursuant to the St. Mary's Medical Center Medical Staff Bylaws.

3.7.2 When trying to verify the information supplied by the applicant, if a particular entry has closed or ceased to operate, the file will proceed as if complete. The applicant shall be notified that the needed verification has not been obtained and will be requested to assist in the process. If after all avenues have been thoroughly tried, the verification will be deemed complete. Due diligence is defined as trying to obtain the verification at least three times by Medical Staff Services from the entity or facility. The file will be presented to the Department for Review and Approval as outlined in Section 5.0 with the unverified item noted.

3.8 Reapplication:

If, at a later date, the applicant is able to obtain necessary information for a full and complete evaluation of his application and request for clinical privileges, he may resubmit his application for consideration.

3.9 Time Frame for Completed Application:

Credentialing decision will be made within 90 days of time that application is complete.

3.10 Duration of Appointment:

All initial appointments shall be considered provisional for a period of twenty-four (24) months during which time an applicant's clinical competence and ethical and moral conduct may be observed by the Chief of the applicable Section or his/her designee. If, at the end of twenty-four (24) months, the physician has had insufficient activity on which to base an assessment of clinical competence, the practitioner's appointment and clinical privileges may not be renewed at the discretion of the Clinical Service Chief. This nonrenewal shall constitute an administrative action that shall not require reporting to the National Practitioner Data Bank and shall not entitle the practitioner to the procedural rights afforded by the St. Mary's Medical Center Medical Staff Bylaws. The biennial reappointment will conclude this provisional period.

3.10.1 For those physicians appointed to the Emergency Department for the purposes of attending a mentoring/fellowship program, the initial appointment will be granted for the duration of the fellowship **only**, as specified by the Chief of the Emergency Section at the time of initial appointment. At the conclusion of the program, the Chief of Section will send a report detailing the training and performance of the participating physician.

3.10.1.1 Should the physician wish to revise or maintain their privileges beyond the completion of the Emergency fellowship program, the physician should send a letter to the Credentials committee along with a "Application for Modification of Staff Status or Privileges" . This must be received in the Credentialing office a ***minimum*** of ***30 days*** prior to the expiration of the physician's initial appointment for consideration by the Credentials Committee. Failure to provide this information as required will result in the expiration of the physician's privileges as specified in the original appointment and the physician will have to reapply as a new applicant.

3.2 Temporary/Disaster Privileges

Upon activation of the hospital's Emergency Management Plan, should the need arise for additional licensed independent practitioners, temporary disaster privileges may be granted on a case by case basis in accordance with Article V Section 2.8 of the Bylaws, Rules, and Regulations.

4.0 Reappointment

In addition to the ongoing reporting responsibilities of Medical Staff members required by §3.4 of these Policies and Procedures, the reappointment process shall be performed at least every twenty-four (24) months but may occur more often in the discretion of the Board of Trustees'. An action, either termination or reappointment, must be rendered at the time of or prior to expiration of the appointment cycle. Practitioners who have not satisfied the CME requirement at the time of the reappointment cycle

will be reappointed conditionally until they have fulfilled this requirement or 90 days, after which time they will be terminated. Applications will be mailed by Medical Staff Services 90 120 days prior to the appointment expiration date.

Generally, appointments are for a twenty-four (24) month period. An appointment not renewed within this period will automatically terminate as an expiration of appointment. Termination of an appointment in this way does not preclude the submission of a reapplication for Initial Application to reestablish privileges.

4.1 Terms of Reappointment:

Reappointment is not automatic. In addition to the qualifications for initial appointment, information submitted in the reappointment process, and such requirements as may be established from time to time by the Board of Trustees, the member will be evaluated based on, but not limited to:

- Current clinical competence;
- Ability to work with other professionals and others in the Hospital
- Satisfactory completion of required FPPE and OPPE pursuant to the Bylaws, Rules, & Regulations
- Information obtained from appropriate licensing boards and the National Practitioner Data Bank;
- For practitioners who have been appointed prior to September 2, 2008 and have had no lapses in credentialing at St. Mary's Medical Center, are exempt from the Board Certification requirement.
- Continuing Medical Education (CME) credits to meet the minimum State of West Virginia and/or Ohio CME requirement within an appointment two (2) year period. Section Chief may impose CME credit standards beyond minimum. The credits must be earned during the two (2) year interval immediately preceding reappointment to the Medical Staff;
- Professional liability claims and suits; Physical and mental capabilities relative to his/her ability to perform the privileges requested; and
- Other services and activities related to his/her professional contribution.

4.1.1 Insufficient Activity for Evaluation:

Reappointment and reappraisal of clinical privileges focuses on a member's clinical activity and demonstrated clinical competence as it relates to Medical Staff quality monitoring and evaluation activity; therefore, a Practitioner, except Emeritus, who has not utilized the Hospital and/or participated in Medical Staff activities for a continuous two (2) year period as required by the Bylaws and Rules and Regulations will be handled as follows: **4.1.1.1** If a provider is currently on the Active Medical Staff and had less than 12 patient contacts per year at SMMC during the previous two years and has had minimal or no administrative activity and is on the Active staff at another TJC approved hospital then the provider's status will be changed to Courtesy Staff if the provider otherwise qualifies. If the provider does not qualify for Courtesy privileges, the provider will be voluntarily removed from staff.

4.1.1.2 If a provider is currently Courtesy Staff and has more than 12 patient contacts at SMMC, the provider must apply for active staff privileges.

4.1.1.3 If any of the above conditions are met, the coordinator will send a letter to the provider outlining the change being recommended. The provider may inform Medical Staff Services if he/she feels the information is inaccurate. Recommendations will be forwarded to the Section Chief along with any additional information submitted by the provider for review and approval.

4.1.2 Failure to be reappointed as outlined in §4.1.1.1 above constitutes an administrative action that shall not require reporting to the National Practitioner Data Bank nor shall it constitute an adverse recommendation as defined in Hearing and Appellate Review Procedures of the Medical Staff Bylaws (Article VII).

4.2 The Recredentialing Application:

It is the responsibility of the applicant to return a signed, dated, and fully completed application and request for clinical privileges with the following:

- Updated copy of license, DEA (See §3.5.2), and certificate of professional liability coverage;
- Information pertaining to malpractice claims activity;
- Work history since initial appointment or previous appointment;
- Evidence of sufficient participation in continuing education during the last two year period to support a reappointment;
- Voluntary or involuntary changes in membership, privileges, or status at other healthcare organizations;
- Voluntary or involuntary relinquishment of licensure or registration;
- Peer references;
- Health status relative to ability to perform the clinical privileges requested;
- Request clinical privileges;
- Attestation statement;
- Copy of board certificate, if certified or recertified during the last two year period;
- Release of information form
- Any additional information needed to update the original application requirements.

4.3 Assessing Competency at Reappointment

When considering reappointments, clinical competency is based primarily on the physician's profile and peer review data. In circumstances where there are insufficient peer review data available when evaluating an applicant for privileges, the organized medical staff uses peer recommendations.

A recommendation(s) from peers (appropriate practitioners in the same professional discipline as the applicant who have personal knowledge of the applicant) reflects a basis for recommending the granting of privileges.

Sources for peer recommendations may include the following:

- An organization performance improvement committee, the majority of whose members are the applicant's peers.
- A reference letter(s), written documentation, or documented telephone conversation(s) about the applicant from a peer(s) who is knowledgeable about the applicant's professional performance and competence.
- A department or major clinical service chairperson who is a peer.
- The medical staff executive committee.

4.3.1 Request(s) for New Privilege(s)

When a member of the medical staff wishes to obtain new or additional privileges performed at SMMC but not previously granted to the member, he/she must contact the Medical Staff Office to determine whether or not the member meets the **criteria** established for the given procedure(s). Should the criteria for the desired procedure require initial proctoring, a "Permission to be Proctored" request form should be completed and forwarded to Medical Affairs. If an outside proctor is to be used, the applicant should make these arrangements and the proctor must apply for staff privileges. (See section 3.2.1)

Upon receipt of the "Permission to be Proctored" request form is submitted, the Medical Staff office will review the member's file, including:

- Status of current West Virginia and/or Ohio licensure with the appropriate medical board;
- Status of current DEA;
- Specialty Board status;
- Information from the National Practitioner Data Bank; and
- Medicare/Medicaid sanctions and investigations from both the Office of Inspector General and Excluded Parties Listing System websites.
- Verification applicant has met all other requirements per criteria

Request to be approved by appropriate Section Chief and forwarded to Credentials Committee for approval. Upon completion of approved proctored cases, member should submit their proctored case evaluations to Medical Affairs.

Once applicant has documentation satisfying the criteria for a requested privilege, he/she should complete the "**Application for Modification of Staff Status or Privileges**" form along with supporting documentation to Medical Affairs. Application to be reviewed by Section Chief, Credentials Committee, Medical Executive Committee, and Board of Trustees' Quality Committee for final approval.

4.4 Failure to Return the Reappointment Application:

Failure to return the application for reappointment before the end of the reappointment period shall be deemed a voluntary resignation from the Medical Staff and the practitioner's membership and privileges shall lapse at the end of his/her current term. The Practitioner shall be notified prior to final action by the Board of Trustees. This nonrenewal shall constitute an administrative action that shall not require reporting to the National Practitioner Data Bank and shall not entitle the practitioner to the procedural rights afforded by the St. Mary's Medical Center Medical Staff Bylaws.

4.4 Reappointment Verification Process:

Upon receipt of a completed (signed and dated) application, Medical Staff Services will verify with accepted sources the contents of the application by collecting the following information:

- Status of current West Virginia and/or Ohio licensure with the appropriate medical board;
- Status of current DEA with appropriate State address;
- Specialty Board status;
- Status of affiliations with other hospitals or healthcare organizations;
- Status of group affiliations;
- Status of Malpractice Claims history for the past two years;
- Information from the National Practitioner Data Bank; and
- Medicare/Medicaid sanctions and investigations from both the Office of Inspector General and Excluded Parties Listing System websites.

This information may be obtained either in writing or verbally. If the information is obtained verbally, the person making the verification shall document in the practitioner's file the date, the person he/she spoke with, the status of affiliation or licensure, issuance and expiration dates where applicable, and the information provided.

4.5 Applicant's Rights Regarding Information:

4.5.1 The applicant has the right to review information submitted by the applicant to support their credentialing.

4.5.2 The applicant has the right to correct erroneous information.

4.5.3 The applicant has the right, upon request, to be informed of the status of their credentialing application.

4.5.4 The applicant is notified of these rights by receiving these Policies and Procedures.

4.6 Inability to Obtain Information

4.6.1 In the event that there is a delay in obtaining any required information, or if clarification of information is needed, the applicant will be notified informed of his/her responsibility to obtain the needed information. Failure of the applicant to adequately respond to a request for the required information within fifteen (15) days will result in discontinuance of the application process. The applicant shall be notified in writing that the application will be withdrawn at the next regularly scheduled meeting of the Credentials Committee. This is an administrative action and shall not constitute an adverse action pursuant to the St. Mary's Medical Center Medical Staff Bylaws.

4.6.2 When trying to verify the information supplied by the applicant, if a particular entry has closed or ceased to operate, the file will proceed as if complete. The applicant shall be notified that the needed verification has not been obtained and will be requested to assist in the process. If, after all avenues have been thoroughly tried, the verification process will be deemed complete. Due diligence is defined as trying to obtain the verification at least three times by Medical Staff Services from the entity or facility. The file will be presented to the Department for Review and Approval as outlined in Section 5.0 with the unverified item noted.

4.7 Reapplication:

If, at a later date, the applicant for reappointment is able to obtain necessary information for a full and complete evaluation of his application and request for renewal of clinical privileges, he may reapply to the Medical Staff through the initial application process.

5.0 Review/Approval Process

All appointments and reappointments will be reviewed as outlined below and final approval rests with the St. Mary's Medical Center's Board of Trustees.

5.1 Section Review:

Once all required application documentation has been received and processed and all verifications and references confirmed, the Chief of the applicable Section, if appropriate, shall then review the application, and, at his/her discretion, conduct a personal interview, except in the case of family or family members or Clinical Service Chiefs. In those instances, the Chief of Staff, Chairman of the Credentials Committee and/or Chief Medical Officer will review the request for clinical privileges. Upon completion of this review, the Chief of Service, or Chief of Staff (when applicable), shall make a recommendation as to the extent of clinical privileges and the proposed category in the Medical Staff. The application with his/her recommendation, shall then be returned to Medical Staff Services. If prior to reappointment of a Physician, Podiatrist or Dentist to the Medical Staff, the Section Chief anticipates recommending an involuntary reduction or total denial of previously granted privileges at St. Mary's Medical Center based on the physician's failure to meet the criteria outlined above in Section 4.1, the Clinical Service Chief is required to notify in writing the affected physician of the specific deficiencies, failure to meet specific deficiencies, failure to meet specific criteria, and/or other documentation supporting the reduction or denial of privileges. Notice shall also be sent to the Chief of Staff and Vice President of Medical Affairs at St. Mary's Medical Center. Such notification will include adequate supporting documentation of the basis for reduction or nonrenewal of privileges. This notice will be given in writing to the physician at least thirty (30) days before their reappointment date to the Medical Staff, unless there is a delay caused by the actions or inactions of the applicant, such as failing to file the credentialing application and information in a timely manner. This notification by the Section Chief shall trigger a review of the information and circumstances by the Chief of Staff and the Vice President of Medical Affairs. In the event of nonresolution, the Section Chief's recommendations shall be forwarded to the Credentials Committee with the supporting documentation and in accordance with Section 5.2 below. The decision, if adverse to the Physician, may be appealed by the Physician as referenced below in Section 5.5.

5.2 Credentials Committee Review:

Following review by the appropriate Section Chief, the Credentials Committee shall review the application and supporting documentation, including all written documentation described in Section 4.1 and 5.1 above, along with the recommendations made to the Credentials Committee by the Section Chief. The Credentials Committee shall make its studied and thoughtful recommendations based on its review of the application and supporting evidence and forward these recommendations to the Medical Executive Committee at its next regularly scheduled meeting.

5.3 Medical Executive Committee:

The Medical Executive Committee will receive the recommendations of the Credentials Committee at its next scheduled meeting. The Medical Center Medical Board or the Executive Committee will then forward its recommendation to the Quality Committee of the Board of Trustees. When there are differences in recommendations between the Section Chief and the Credentials Committee, the Medical Executive Committee will review both recommendations and make a report to the Quality Committee of the Board of Trustees.

5.4 Quality Committee of the Board of Trustees

The Quality Committee of the Board of Trustees will review the recommendations of the Medical Executive Committee and forward a recommendation to the St. Mary's Medical Center Board of Trustees.

5.4 St. Mary's Medical Center Board of Trustees

Medical Staff appointments, reappointments, changes of status or privileges, and terminations shall be made by the Board of Trustees based upon recommendations by the Quality Committee of the Board, the Medical Executive Committee, the Credentials Committee and the Section Chiefs in accordance with the Medical Center Medical Staff Bylaws.

5.5 Adverse Recommendations:

When the recommendation of the Board of Trustees is adverse to the applicant either in respect to staff membership or clinical privileges, the Medical Staff Bylaws shall be followed as to notification and appeal.

5.6 Notification to Applicant

The applicant will receive written notification of his/her Medical Staff status and clinical privileges within thirty (30) days of the Board of Trustees rendering its decision.

6.0 Confidentiality

All credentials files will be kept in cabinets in secured offices within Medical Staff Services. Access to credentials files is limited to the following: appropriate Medical Staff Services staff, members of the Credentials Committee, St. Mary's Medical Center legal counsel, St. Mary's Medical Center Office of Risk Management, Section Chief of physician's specialty, the Chief of Staff, Vice President for Medical Affairs, and others who may be otherwise authorized. These files shall be privileged pursuant to law.

7.0 Physician's Rights

Medical Staff credentials files are the property of the St. Mary's Medical Center.

7.1 Access to File:
Each physician shall have access to review any information he/she submitted with the application for appointment or reappointment and clinical privileges. If requested, the physician may be provided a summary of information gathered in the credentialing process without identifying the source unless required to be released by law. Information may only be viewed in Medical Staff Services (MSS) under the supervision of an authorized representative of the MSS staff.

7.2 Conflicting Information:

When information is received which differs significantly from that provided by the physician in his/her application for credentialing or recredentialing, the individual physician will be notified in writing and requested to respond within fifteen (15) days either verbally or in writing. A verbal response will be documented by Medical Staff Services staff and kept in the record. Failure on the part of the physician to respond to a request for clarification of conflicting information shall result in withdrawal of the application in accordance with 3.7 of the Credentialing Policies and Procedures.

Revised and approved by BOT Quality Committee: 12/07/2017

Appendix A

TB Screening Requirements

All physicians and Allied Health Practitioners must submit evidence of negative Tuberculin testing with their initial appointment application and annually thereafter.

Acceptable Documentation may include:

1. A Tuberculin skin test (TST) performed within the past calendar year, including those with a history of BCG vaccination (CDC). In order to accept a TST result from another facility, the test must be administered and read by the following qualified individuals: Occupational Health professional, Employee Health professional, ID professional, or a TB Control officer with the official title and signature on official letterhead. Should the TST produce positive results, then the practitioner should undergo an Interferon gamma release assay IGRA blood test.

2. An IGRA may be used in place of a TST. Should the IGRA indicate a positive result, the practitioner will submit results of a subsequent negative chest x-ray.

Applicants submitting any positive results may be reviewed by St. Mary's Infection Control physicians and also be referred to their local health department for preventive treatment and/or follow up.

Interpretation of results will be as outlined in the Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health Care Facilities, 2005. (CDC recommendations)

Orientation, Education & Training

ST. MARY'S MEDICAL CENTER

HUMAN RESOURCES POLICY MANUAL

Subject	**ORIENTATION, EDUCATION & TRAINING**
Policy No. E-25	**Department: Human Resources**
Prepared By: SBR/CM	**Approved By: Policy & Procedure**
Date Issued: 4/1/19	**Previous Date:** 6/23/16

POLICY: St Mary's Medical Center ("SMMC") will provide orientation, training, and education to its staff in order for staff to fulfill their specified responsibilities.

PURPOSE: To provide a system of orientation, training and education for SMMC staff.

PROCEDURE:

I. ORIENTATION

A. All newly hired employees are required to attend Medical Center-wide orientation during the introductory period. Contractual staff, volunteers and security officers are required to participate in a SMMC orientation program. The Medical Center-wide orientation program is normally presented twice a month. Additional sessions are scheduled as needed. Documentation of attendance is maintained in Human Resources or the appropriate department. Contents of the Medical Center-wide orientation program include the Medical Center's history, mission and values, Spiritual Care, infection control/OSHA, environment of care (safety, security, hazardous materials/wastes, emergency preparedness, life safety/fire program, medical equipment, utility system), confidentiality, risk management, performance improvement, patient rights, general overview: benefit, compensation and other HR policies, Medical Center communications, the corporate compliance program, employee assistance program (EAP), radiation safety, tax sheltered annuities (TSA's), safety management/back injuries, Social Work Services-protective services/victim abuse, and patient safety including falls prevention.

B. Each Manager will be responsible for department-specific orientation. A written program for orientation may include but will not be limited to: policies, procedures and rules specifically related to the individual's job; the department's goals and objectives; review of the individual's job description; performance expectations; the individual's role in the programs for infections, fire, safety and disaster and hazardous materials within the department; dress code; performance improvement activities in progress; any specific skills that are required; competencies and method used to assess the competencies, and the proper use of all equipment in the department.

C. In all patient care areas orientation will also include, when appropriate: aseptic techniques; specific OSHA/infection control regulations; ; patient flow; traffic control; hand washing; sterilization system; and appropriate wearing apparel in each specific area.

D. Department specific orientation, as indicated in (IB) above, must be provided to each employee who transfers into a new department permanently or who works in more than one department.

II. **Continuing Education**

A. Appropriate job related continuing education will be available to all employees and various contractual personnel. Each Manager is responsible for providing this.

B. SMMC Organizational Development and Learning ("ODAL") provides continuing education programs and monthly calendars are available on the intranet. Physicians and staff members whose expertise is applicable to specific subjects may be requested to provide education.

C. ODAL provides Medical Center-wide required general information (i.e. Intranet or On-line Modules) on specific days each month which focus on safety, disaster, confidentiality, radiation safety, fire, hazardous materials, OSHA and infection control. Schedules are sent to each Director/Department Manager at the start of each year and attendance is mandatory for employees. Directors/Department Managers are responsible for scheduling staff to attend these.

D. In-service should be done on all new equipment/supplies, when appropriate, and annually on old equipment if there has been an update or change in the equipment. All employees who will be using the equipment/supplies must attend. Documentation of attendance is required.

E. In-services will be provided for any new policies/procedures and any changes in procedures for delivering healthcare. In-services may be the result of changes in; risk or safety issues; types of patients served;, age of patients; , advances in technology, or at staff request.

F. Evaluation of the appropriateness and effectiveness of orientation, training and education activities will be done at least annually and documented. On an ongoing basis, SMMC will collect data on competence patterns and trends to identify and respond to the staff's learning needs.

Adpt: 03/22/93
Rvwd: 10/18/96; 04/04/97; 1/01/06; 4/1/19
Rvsd: 8/16/99 ; 7/2/2012; 7/28/15, 7/23/16

SECTION N: FINANCIAL FEASIBILITY

1. **Submit audited financial reports for the most recent two (2) fiscal years. If audited financial reports are not prepared, submit the following financial statements: (1) statement of revenues and expenses; (2) balance sheet; (3) statement of changes in fund balances; and, (4) statement of cash flows for each of last two (2) fiscal years. If a Form 10-K is required to be submitted to the U.S. Securities and Exchange Commission by either the applicant or a related entity, submit the Form 10-K for the preceding two (2) years. The Form 10-K may be submitted on CD.**

   See Exhibit N-1.

2. **Provide a preliminary financial feasibility study including, at a minimum, pro forma financial statements to include a three (3) year projection of revenues and expenses for the project. If revenues do not equal expenses by the end of the third year, identify other sources of revenue or income which will subsidize the deficit. Applicants must demonstrate in their financial projections that all indigent persons can be served without jeopardizing the financial viability of the project. Please note that the applicant must address the criteria in the applicable CON Standards. Provide a listing of assumptions utilized in the preparation of the financial statements including staffing and salaries, expenses, utilization data, fee schedule or charges, and projected revenues.**

   See Exhibit N-2.

3. **Provide historical and projected utilization for the facility using the following tables. Unless directed otherwise, provide data for the two past fiscal years, current and future fiscal years prior to the project's implementation, and the first two years after completion of the project.**
   If this is a start-up project, provide data for the first three years of operation.
   On a separate sheet, set forth all the assumptions upon which the projections are based.

   See Exhibit N-3.

INPATIENT ACUTE CARE DATA

Provide the month and day for fiscal year ending 9/30

a. UTILIZATION STATISTICS	PAYOR CLASSIFICATION			
	MEDICARE	MEDICAID	OTHER	TOTAL
Inpatient Days:				
FY 2018	55,419	15,652	14,560	85,631
FY 2019	56,908	15,099	15,100	87,107
FY 2020	55,858	14,388	14,388	84,634
FY 2021	56,908	15,099	15,100	87,107
FY 2022	57,477	15,250	15,251	87,978
FY 2023	58,052	15,402	15,404	88,858
Inpatient Discharges:				
FY 2018	9,306	2,328	3,167	14,801
FY 2019	9,859	2,327	3,312	15,498
FY 2020	9,704	2,274	3,184	15,162
FY 2021	9,859	2,327	3,312	15,498
FY 2022	9,982	2,356	3,353	15,692
FY 2023	10,107	2,386	3,395	15,888

b. AVERAGE LENGTH OF STAY	PAYOR CLASSIFICATION			
	MEDICARE	MEDICAID	OTHER	TOTAL
FY 2018	5.96	6.72	4.60	5.79
FY 2019	5.77	6.49	4.56	5.62
FY 2020	5.76	6.33	4.52	5.58
FY 2021	5.77	6.49	4.56	5.62
FY 2022	5.76	6.47	4.55	5.61
FY 2023	5.74	6.46	4.54	5.59

c. BEDS AND OCCUPANCY	LICENSED BEDS	PERCENTAGE OCCUPANCY LICENSED	BEDS SET UP STAFFED	PERCENTAGE OCCUPANCY SET UP
FY 2018	346	67.8%	328	71.5%
FY 2019	346	69.0%	328	72.8%
FY 2020	346	67.0%	328	70.7%
FY 2021	346	69.0%	328	72.8%
FY 2022	346	69.7%	328	73.5%
FY 2023	346	70.4%	328	74.2%

SKILLED NURSING UNIT
Provide the month and day for fiscal year ending 9/30

d. UTILIZATION STATISTICS	PAYOR CLASSIFICATION			
	MEDICARE	MEDICAID	OTHER	TOTAL
Inpatient Days:				
FY 2018	5,029	-	282	5,311
FY 2019	5,425	-	221	5,646
FY 2020	5,276	-	220	5,496
FY 2021	5,425	-	221	5,646
FY 2022	5,479	-	223	5,702
FY 2023	5,534	-	225	5,759
Inpatient Discharges:				
FY 2018	366	-	20	386
FY 2019	401	-	16	417
FY 2020	364	-	15	379
FY 2021	401	-	16	417
FY 2022	405	-	16	421
FY 2023	409	-	16	425

e. AVERAGE LENGTH OF STAY	PAYOR CLASSIFICATION			
	MEDICARE	MEDICAID	OTHER	TOTAL
FY 2018	13.74	-	14.10	13.76
FY 2019	13.53	-	13.81	13.54
FY 2020	14.50	-	14.50	14.50
FY 2021	13.53	-	13.81	13.54
FY 2022	13.53	-	13.81	13.54
FY 2023	13.53	-	13.81	13.54

f. BEDS AND OCCUPANCY	LICENSED BEDS	PERCENTAGE OCCUPANCY LICENSED	BEDS SET UP STAFFED	PERCENTAGE OCCUPANCY SET UP
FY 2018	19	76.6%	19	76.6%
FY 2019	19	81.4%	19	81.4%
FY 2020	19	79.3%	19	79.3%
FY 2021	19	81.4%	19	81.4%
FY 2022	19	82.2%	19	82.2%
FY 2023	19	83.0%	19	83.0%

PSYCHIATRICT UNIT

Provide the month and day for fiscal year ending 9/30

g. UTILIZATION STATISTICS	PAYOR CLASSIFICATION			
	MEDICARE	MEDICAID	OTHER	TOTAL
Inpatient Days:				
FY 2018	1,608	3,212	906	5,726
FY 2019	1,645	2,896	990	5,531
FY 2020	1,676	2,905	1,006	5,587
FY 2021	1,645	2,896	990	5,531
FY 2022	1,661	2,925	1,000	5,586
FY 2023	1,678	2,954	1,010	5,642
Inpatient Discharges:				
FY 2018	137	386	114	637
FY 2019	133	371	131	635
FY 2020	125	345	125	595
FY 2021	133	371	131	635
FY 2022	134	375	132	641
FY 2023	136	378	134	648

h. AVERAGE LENGTH OF STAY	PAYOR CLASSIFICATION			
	MEDICARE	MEDICAID	OTHER	TOTAL
FY 2018	11.74	8.32	7.95	8.99
FY 2019	12.37	7.81	7.56	8.71
FY 2020	13.41	8.42	8.05	9.39
FY 2021	12.37	7.81	7.56	8.71
FY 2022	12.37	7.81	7.56	8.71
FY 2023	12.37	7.81	7.56	8.71

i. BEDS AND OCCUPANCY	LICENSED BEDS	PERCENTAGE OCCUPANCY LICENSED	BEDS SET UP STAFFED	PERCENTAGE OCCUPANCY SET UP
FY 2018	28	56.0%	28	56.0%
FY 2019	28	54.1%	28	54.1%
FY 2020	28	54.7%	28	54.7%
FY 2021	28	54.1%	28	54.1%
FY 2022	28	54.7%	28	54.7%
FY 2023	28	55.2%	28	55.2%

j. UTILIZATION STATISTICS

Service	Value for Standard Units of Measure	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Operating Rooms (General)	Surgery Minutes	1,138,656	1,186,921	930,808	1,186,921	1,204,725	1,222,796
	Patients						
Operating Rooms (Ambulatory)	Surgery Minutes	9,683	9,955	8,804	9,955	10,104	10,256
	Patients						
Operating Rooms (Open Heart)	Surgery Minutes						
	Patients						
Labor and Delivery Room	Births	373	364	291	364	360	357
Outpatient							
Clinic	Patient Visits	176,249	187,587	175,718	187,587	193,215	199,011
ER	Patient Visits	52,898	49,221	45,494	49,221	48,729	48,242
Other ____	Patients						
Psychiatric	Patient Visits						
Cardiac Catheterization	Procedures						
Radiological	Procedures	142,303	141,128	117,601	141,128	142,539	143,965
CT Scan	Procedures	45,828	48,131	44,983	48,131	49,334	50,568
MRI scan	Procedures	7,658	7,701	6,766	7,701	7,778	7,856
Kidney Transplant	Procedures						
Lithotripsy	Procedures	190	134	98	134	135	137
Radiation Therapy	Procedures						
	Patients						
Home Health	Visits						
	Patients						

Audited Financial Statements

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Cabell Huntington Hospital, Inc. and Subsidiaries

Consolidated Financial Statements
and Supplementary Information

September 30, 2019 and 2018

Cabell Huntington Hospital, Inc. and Subsidiaries

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September 30, 2019 and 2018

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Independent Auditors' Report

To the Board of Directors of
Cabell Huntington Hospital, Inc.

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of Cabell Huntington Hospital, Inc. and Subsidiaries, which comprise the consolidated balance sheets as of September 30, 2019 and 2018, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated 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 consolidated 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 consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated 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 consolidated 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 consolidated 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 consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Cabell Huntington Hospital Inc. and Subsidiaries as of September 30, 2019 and 2018, and the results of its operations, changes in net assets and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Report on Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating and combining schedules on pages 41 through 48 are presented for purposes of additional analysis rather than to present the financial position, results of operations, changes in net assets and cash flows of the individual companies and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated 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 consolidated financial statements as a whole.

Baker Tilly Virchow Krause, LLP

Pittsburgh, Pennsylvania
December 20, 2019

Cabell Huntington Hospital, Inc. and Subsidiaries

Consolidated Balance Sheets
September 30, 2019 and 2018

	2019	2018
Assets		
Current Assets		
Cash and cash equivalents	$ 202,032,591	$ 142,785,484
Patient accounts receivable, net	142,133,689	134,546,574
Inventories of supplies	21,308,422	19,975,208
Estimated third-party payor settlements	17,923,105	18,935,797
Prepaid expenses and other current assets	23,255,675	23,427,811
Total current assets	406,653,482	339,670,874
Investments		
Board designated	281,690,522	310,129,230
Funds held by trustee	25,984,789	36,967,222
Funds held by Foundations	1,944,305	1,720,934
Total investments	309,619,616	348,823,386
Property and Equipment, Net	449,446,755	443,766,869
Partnership Investments	14,293,937	13,189,768
Other Assets, Net	19,830,617	21,173,859
Total assets	$ 1,199,844,407	$ 1,166,624,756

	2019	2018
Liabilities and Net Assets		
Current Liabilities		
Lines of credit	$ 427,196	$ 361,344
Current maturities of long-term debt	8,134,776	4,830,118
Accounts payable	38,609,936	36,373,349
Accrued expenses	105,821,642	104,914,004
Estimated third-party payor settlements	1,977,959	2,707,354
Total current liabilities	154,971,509	149,186,169
Long-Term Debt, Net	352,895,993	356,397,035
Derivative Financial Instruments	12,671,446	7,535,120
Other Liabilities	2,285,376	2,520,972
Accrued Professional Liability	18,625,269	17,466,929
Accrued Pension and Postretirement Liabilities	306,507,703	229,866,723
Total liabilities	847,957,296	762,772,948
Net Assets		
Controlling interest	346,695,744	397,284,956
Noncontrolling interest	(27,653)	1,101,857
Total net assets without donor restrictions	346,668,091	398,386,813
Net assets with donor restrictions	5,219,020	5,464,995
Total net assets	351,887,111	403,851,808
Total liabilities and net assets	$ 1,199,844,407	$ 1,166,624,756

See notes to consolidated financial statements

Cabell Huntington Hospital, Inc. and Subsidiaries

Consolidated Statements of Operations
Years Ended September 30, 2019 and 2018

	2019	2018
Revenues		
Patient service revenues	$ 1,048,978,987	$ 779,223,364
Provision for bad debts	-	(39,917,426)
Net patient service revenues	1,048,978,987	739,305,938
Other revenues, including net assets re eased from restrictions for operations	73,063,322	66,860,109
Total revenues	1,122,042,309	806,166,047
Expenses		
Salaries and wages	362,452,222	250,235,270
Employee benefits	138,996,938	94,813,225
Supplies	244,752,085	159,049,366
Professional fees	106,589,870	89,721,667
Purchased services	81,731,928	59,455,259
Plant operations	63,201,655	46,403,054
Interest	13,243,738	8,809,238
Depreciation and amortization	34,889,296	27,371,814
Provider tax	26,586,471	19,108,166
Insurance	8,632,908	4,218,073
Other	21,627,371	19,278,055
Total expenses	1,102,704,482	778,463,187
Operating income	19,337,827	27,702,860
Other Income (Loss)		
Investment income	12,881,186	17,364,073
Change in fair value of derivative financial instruments	(5,136,326)	4,570,008
Equity income from partnership investments	1,008,867	1,185,952
Inherent contribution in acquisition of St. Mary's Medical Center (Note 3)	-	27,528,609
Acquisition costs	(531,071)	(4,169,246)
Revenues in excess of expenses	27,560,483	74,182,256
Pension and Postretirement Liabilities Adjustment	(81,531,669)	33,657,533
Net Assets Released From Restrictions for Property and Equipment	2,666,649	1,303,421
Equity Distributions	(414,185)	(378,004)
Change in Noncontrolling Interest in Acquiree	-	941,152
(Decrease) increase in net assets without donor restrictions	$ (51,718,722)	$ 109,706,358

See no'es to consolidated financial statements

Cabell Huntington Hospital, Inc. and Subsidiaries

Consolidated Statements of Changes in Net Assets
Years Ended September 30, 2019 and 2018

	2019	2018
Net Assets Without Donor Restrictions		
Revenues in excess of expenses	$ 27,560,483	$ 74,182,256
Pension and postretirement liabilities adjustment	(81,531,669)	33,657,533
Net assets released from restrictions for property and equipment	2,666,649	1,303,421
Equity distributions	(414,185)	(378,004)
Change in noncontrolling interest in acquiree	-	941,152
(Decrease) increase in net assets without donor restrictions	(51,718,722)	109,706,358
Net Assets With Donor Restrictions		
Contributions and investment income, net	3,197,438	2,189,496
Net assets released from restrictions	(3,443,413)	(2,155,627)
Inherent contribution in acquisition of St. Mary's Medical Center (Note 3)	-	2,153,814
(Decrease) increase in net assets with donor restrictions	(245,975)	2,187,683
Change in net assets	(51,964,697)	111,894,041
Net Assets, Beginning	403,851,808	291,957,767
Net Assets, Ending	$ 351,887,111	$ 403,851,808

See notes to consolidated financial statements

Cabell Huntington Hospital, Inc. and Subsidiaries

Consolidated Statements of Cash Flows
Years Ended September 30, 2019 and 2018

	2019	2018
Cash Flows From Operating Activities		
Change in net assets	$ (51,964,697)	$ 111,894,041
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	34,889,296	27,371,814
Amortization of debt issuance costs, accretion of bond discount, and loss on refinancing	(378,896)	1,946,682
Pension and postretirement liabilities adjustment	81,531,669	(33,657,533)
Net realized and unrealized gains on investments	(3,119,736)	(12,034,029)
Change in fair value of derivative financial instruments	5,136,326	(4,380,971)
Equity income from partnership investments	(1,008,867)	(1,185,952)
Distributions received from partnership investments	269,000	861,750
Restricted contributions and investment income	(3,197,438)	(2,189,496)
Other operating activities	(41,596)	(213,815)
Provision for bad debts	-	39,917,426
Change in noncontrolling interest in acquiree	-	(941,152)
Inherent contribution in acquisition of St. Mary's Medical Center	-	(21,105,719)
Changes in assets and liabilities:		
Patient accounts receivable, net	(7,587,115)	(38,993,486)
Inventories of supplies	(1,333,214)	(1,332,856)
Prepaid expenses and other current assets	172,136	10,722,776
Estimated third-party payor settlements	283,297	(10,687,343)
Other assets	126,000	1,356,000
Accounts payable	2,236,587	(20,170,613)
Accrued expenses	672,042	43,428,651
Other liabilities	(3,532,349)	(16,650,955)
Net cash provided by operating activities	53,152,445	73,955,220
Cash Flows From Investing Activities		
Purchases of property and equipment	(35,539,563)	(42,887,188)
Net sales (purchases) of investments	42,323,506	(44,566,529)
Change in other assets	1,217,242	563,832
Capital contributions to investees	(322,706)	-
Cash paid in connection with acquisition of St. Mary's Medical Center, net of cash acquired	-	(106,473,577)
Net cash provided by (used in) investing activities	7,678,459	(193,363,462)
Cash Flows From Financing Activities		
Repayment of long-term debt	(4,847,087)	(72,243,390)
Repayment of lines of credit	(4,148)	(4,611)
Proceeds from lines of credit	70,000	-
Restricted contributions and investment income	3,197,438	2,189,496
Proceeds from issuance of long-term debt, including premium of $15,737,163	-	266,391,693
Payment of financing costs	-	(4,682,711)
Net cash (used in) provided by financing activities	(1,583,797)	191,650,477
Increase in cash and cash equivalents	59,247,107	72,242,235
Cash and Cash Equivalents, Beginning	142,785,484	70,543,249
Cash and Cash Equivalents, Ending	$ 202,032,591	$ 142,785,484
Supplemental Disclosure of Cash Flow Information		
Cash paid for interest	$ 13,743,413	$ 6,452,576
Supplemental Disclosure of Noncash Financing Activities		
Capital leases incurred for purchase of property and equipment	$ 5,029,599	$ -

See notes to consolidated financial statements

1. Nature of Operations and Basis of Presentation

Cabell Huntington Hospital, Inc. (CHHI) is an acute care hospital facility in Huntington, West Virginia, that provides integrated health care solutions to residents of Cabell County and surrounding communities.

On May 1, 2018, CHHI became the sole member of St. Mary's Medical Center, Inc. (SMMC), an acute care hospital facility in Huntington, West Virginia, that provides integrated health care solutions to residents of Cabell County and surrounding communities (Note 3).

The consolidated financial statements include the accounts of CHHI and SMMC and their subsidiaries (collectively, the System), as described below:

- Cabell Huntington Hospital Foundation, Inc. (CHHF) - raises and holds funds for the support and benefit of CHHI.
- CHH-Cabell Development Corporation (CHH-DEV) - CHHI maintains a 51 percent equity interest in CHH-DEV, which owns certain long-lived assets used for outpatient surgery.
- Cabell Huntington Hospital Auxiliary, Inc. (Auxiliary) - operates solely for the benefit of CHHI by providing services to and coordinating fund raising activities for CHHI.
- St. Mary's Medical Center Foundation, Inc. (SMMCF) - raises and holds funds for the support and benefit of SMMC.
- St. Mary's Medical Management, LLC (SMMM) and Subsidiaries - employed physician group of SMMC. Its subsidiaries include:
    - St. Mary's Hospitalist Services, LLC (SMH) - employed hospitalist group of SMMM.
    - Three Gables Surgery Center, LLC (TGSC) - SMMM maintains a 52.34 percent equity interest in TGSC, a for-profit hospital located in Proctorville, Ohio.
- Mountain Regional Services, Inc. (MRS) - owns certain real estate located in the vicinity of CHHI and used for parking or held for future expansion.
- Tri-State MRI (TSM) - operated a magnetic resonance imaging unit; this entity was dissolved in September 2019.
- Mountain Health Network, Inc. (MHN) and Subsidiary - provides management services for the System. Its subsidiary incluces:
    - Mountain Health Ventures, Inc. (MHV) - corporation organized to invest in health related investments.
- Occumed, LLC (Occumed) - CHHI maintains a 68.46 percent equity interest in Occumed, which provides urgent care and occupational medicine and related services.
- Vanguard Financial Services, Inc. (VFS) - collection agency specializing in the area of health care debt collection.

The minority ownership interest of the subsidiaries is treated as a noncontrolling interest in the consolidated financial statements. All significant intercompany balances and transactions and amounts have been eliminated in consolidation.

2. Significant Accounting Policies

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financia statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Subsequent Events

The System evaluated subsequent events for recognition or disclosure through December 20, 2019, the date the consolidated financial statements were issued.

Cash and Cash Equivalents

Cash and cash equivalents consist of cash on deposit and temporary investments with financial institutions, which have original maturities of three months or less at the date of purchase. The carrying amount of cash equivalents approximates fair value.

The System maintains cash and cash equivalent accounts that may at times exceed federally insured limits. The System has not experienced any losses from maintaining these accounts in excess of federally insured limits. Management believes it is not subject to significant risks associated with these accounts.

Patient Accounts Receivable

The System assesses collectabi ity on patient contracts prior to the recognition of net patient service revenues. Patient accounts receivable are recorded at net realizable value. Accounts are written off through bad debt expense when the System has exhausted all collection efforts and determines accounts are impaired based on changes in patient credit worthiness. Prior to October 1, 2018, accounts receivable were reduced by an allowance for doubtful accounts. Such allowance was approximately $71,460,000 at September 30, 2018.

Inventories

Inventories are stated at the lower of cost or net realizable value. Certain costs are determined on a weighted average basis and other costs are determined on a first-in, first-out basis.

Pledges Receivable

Unconditional pledges to contribute cash and other assets are reported at their estimated fair value at the date the promise is received Pledges receivable that are expected to be collected within one year are recorded at their net realizable value. Pledges receivable that are expected to be collected in future years are recorded at the present value of estimated net realizable future cash flows. The current portion of pledges receivable was approximately $664,000 in 2019 and $390,000 in 2018, and is included in prepaid expenses and other current assets in the consolidated balance sheets. The long-term portion of pledges receivable was approximately $924,000 in 2019 and $557,000 in 2018, and is included in other assets, net in the consolidated balance sheets.

The System annually evaluates the collectability of its pledges receivable and either reserves for or writes off uncollectible pledges when it is determined the pledge is uncollectible. Recoveries of accounts previously written off are recorded as a reduction to uncollectible pledge losses when received.

Investments and Investment Risk

Investments include funds set aside by the Board of Directors (the Board), primarily for future capital improvements, over which the Board retains control and may, at its discretion, subsequently use for other purposes; funds held by trustees under debt agreements; and funds held by the foundations.

Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value. Investment income or loss (including realized and unrealized gains and losses on investments, interest, and dividends) is included in revenues in excess of expenses unless the income or loss is restricted by donor or law.

The System's investments are comprised of a variety of financial instruments and are managed by investment advisors. The fair va ues reported in the consolidated balance sheet are subject to various risks including changes in the equity markets, the interest rate environment, and general economic conditions. Due to the level of risk associated with certain investment securities and the level of uncertainty related to changes in the fair value of investment securities, it is reasonably possible that the amounts reported in the consolidated financial statements could change materially in the near term.

Property and Equipment

Property and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful lives of the assets, generally ranging from 3 to 40 years, on a straight-line basis. Such lives, in the opinion of management, are adequate to allocate asset costs over their productive lives. Maintenance, repairs, and minor improvements are expensed as incurred. Equipment under capital lease is amortized on the straight-line method over the shorter of the lease term or the estimated useful life of the equipment. Such amortization is included in depreciation and amortization in the consolidated statements of operations.

Interest costs incurred on borrowed funds, net of income earned, during the period of construction of capital assets are capitalized as a component of the cost of acquiring those constructed assets. No interest costs were capitalized in 2019 or 2018.

Gifts of long-lived assets such as land, buildings, or equipment are recorded at fair value and reported as support without donor restrictions unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Expirations of donor restrictions are reported when the donated or acquired long-lived assets are p aced in service.

Impairment of Property and Equipment

Property and equipment are evaluated for impairment whenever events or changes in circumstances indicate the carrying value of an asset may not be recoverable from the estimated future cash flows expected to result from its use and eventual disposition. If expected cash flows are less than the carrying value, an impairment loss is recognized equal to an amount by which the carrying value exceeds the fair value of assets. No impairment losses were recognized in 2019 or 2018.

Partnership Investments

Partnership investments include the System's investment in several entities in which the System has a financial interest. Where the System has the ability to influence management, or has a 20 percent but not more than 50 percent interest in the entity, the investment is recorded using the equity method and adjusted for the System's proportionate share of the entity's undistributed earnings or losses. All other investments in such entities are recorded at cost.

Debt Issuance Costs

Costs incurred in connection with the issuance of long-term debt have been deferred and are being amortized over the term of the related debt using the straight-line method, which approximates the effective interest method. Such costs are reflected as a reduction of long-term debt in the consolidated balance sheets. Amortization of debt issuance costs was approximately $156,000 in 2019 and $855,000 in 2018, and is included in interest expense in the consolidated statements of operations.

In conjunction with the issuance of the 2018 Series Bonds (Note 11), the System wrote off debt issuance costs totaling approximately $1,091,000 in 2018, which is included in interest expense in the consolidated statements of operations.

Derivative Financial Instruments

The System entered into interest rate swap agreements, which are considered derivative financial instruments, to manage its interest rate risk on certain long-term debt obligations (Note 12). The interest rate swap agreements are reported at fair value in the consolidated balance sheets and related changes in fair value are reported in the consolidated statements of operations as a change in fair value of derivative financial instruments.

Estimated Professional Liability

The provision for estimated medical malpractice claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported including costs associated with litigation or settling claims. Anticipated insurance recoveries associated with reported claims are reported separately in the System's consolidated balance sheets at net realizable value, and are included in other assets, net.

Classification of Net Assets

Net assets, revenues, gains and losses are classified based on the existence or absence of donor imposed restrictions. Accordingly, net assets and changes therein are classified and reported as follows:

Net Assets Without Donor Restrictions - net assets available for use in general operations and not subject to donor restrictions. All revenue not restricted by donors and donor restricted contributions whose restrictions are met in the same period in which they are received are accounted for in net assets without donor restrictions.

Net Assets With Donor Restrictions - net assets subject to donor imposed restrictions. Some donor-imposed restrictions are temporary in nature, such as those that will be met by the passage of time or other events specified by the donor. Other donor-imposed restrictions are perpetual in nature, where the donor stipulates that resources be maintained in perpetuity. All revenues restricted by donors as to either timing or purpose of the related expenditures or required to be maintained in perpetuity as a source of investment income are accounted for in net assets with donor restrictions. When a donor restriction expires, that is when a stipulated time restriction ends or purpose restriction is accomplished, net assets with donor restrictions are reclassified to net assets without donor restrictions and reported in the consolidated statements of operations as net assets released from restrictions.

Net Patient Service Revenues

Net patient service revenues are recognized at the amount that reflects the consideration to which the System expects to be entitled in exchange for providing patient care. These amounts are due from patients, third-party payors (including commercial and governmental programs), and others and includes variable consideration for retroactive revenue adjustments due to the settlement of audits, reviews and investigations. Generally, the System bills the patients and third-party payors several days after the services are performed and/or the patient is discharged from the facility. Revenue is recognized as performance obligations are satisfied.

Performance obligations are determined based on the nature of the services provided by the System. Revenues for performance obligations satisfied over time are recognized based on the actual charges incurred in relation to total expected (or actual) charges. The System believes this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the inputs needed to satisfy the obligation. Generally, performance obligations satisfied over time relate to patients in the hospital receiving inpatient acute care services. The System measures the performance obligation from admission into the hospital, or the commencement of an outpatient service, to the point when it is no longer required to provide services to that patient, which is generally at the time of discharge or completion of the outpatient services. Revenue for performance obligations satisfied at a point in time is generally recognized when goods or services are provided and the System does not believe it is required to provide additional services to the patient.

All of the System's performance obligations relate to contracts with a duration of less than one year. Therefore, the System has elected to apply the optional exemptions provided in Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 606-10-50-14(a) and as a result is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. The unsatisfied or partially unsatisfied performance obligations referred to above are primarily related to inpatient acute care services at the end of the reporting period. The performance obligations for these contracts are generally completed when the patients are discharged, which generally occurs within days or weeks of the end of the reporting period.

The System determines the transaction price based on standard charges for services provided, reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured or underinsured patients in accordance with the System's policies, and/or implicit price concessions provided to uninsured or underinsured patients. The System determines its estimates of contractual adjustments and discounts based on contractual agreements, its discount policies, and historical experience. The System determines its estimates of implicit price concessions based on its historical collection experience with a respective class of patient using a portfolio approach as a practical expedient to account for patient contracts as a collective group rather than individually. The financial statement effects of using this practical expedient are not materially different from an individual contract approach.

The System has elected the practical expedient allowed under FASB ASC 606-10-32-18 and does not adjust the promised amount of consideration from patients and third party payors for the effects of a significant financing component due to the System's expectation that the period between the time the service is provided to a patient and the time that the patient or a third-party payor pays for that service will be one year or less. The System does, in certain instances, enter into payment agreements with patients that allow payments in excess of one year. However, in these cases the financing component is not deemed to be significant to the contract.

Charity Care

The System provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the System does not pursue collection of amounts determined to qualify as charity care, such amounts are not reported as a component of net patient service revenues or patient accounts receivable (Note 5).

The System has not changed its charity care or uninsured discount policies during fiscal years 2019 or 2018, other than to incorporate the existing policies of SMMC and its subsidiaries during 2018 (Note 3). The financial assistance policies of SMMC do not differ significantly from those of CHHI.

Measure of Operations and Performance Indicator

The consolidated statements of operations include the determination of operating income and revenues in excess of expenses. Operating income includes only those operating revenues and expenses that are an integral part of the System's healthcare services and supporting activities and net assets released from donor restrictions to support operating expenditures. Revenues in excess of expenses includes all operating activities, as well as investment income (including realized gains and losses, interest, dividends, and investment expenses), change in the fair value of derivative financial instruments, equity income from partnership investments, inherent contribution in acquisition, and acquisition costs.

Changes in net assets without donor restrictions which are excluded from the determination of revenues in excess of expenses, consistent with industry practice, include changes in pension and postretirement benefit obligations, contributions of long-lived assets (including assets acquired using contributions that by donor restrictions are to be used for the purpose of acquiring such assets), equity contributions and distributions, change in noncontrolling interest in acquiree, and permanent transfers of assets to and from affiliates for other than goods and services.

Medicaid Provider Tax

The West Virginia Broad Based Health Care Related Tax of 1993 assesses a tax on net patient service revenues at rates ranging from 1.75 percent to 5.50 percent, depending on the type of services provided. Additionally, the West Virginia Department of Tax and Revenue assesses a tax on net patient service revenues related to the Directed Payment Program (DPP), formerly known as the Upper Payment Limit (UPL) program (Note 5). The System incurred related taxes of approximately $26,586,000 in 2019 and $19,108,000 in 2018.

Federal and State Income Taxes

CHHI, SMMC, CHHF, SMMCF and Auxiliary are tax-exempt organizations and are not subject to federal or state income taxes in accordance with Section 501(c)(3) of the Internal Revenue Code. On such basis, they will not incur any liability for income taxes, except for possible unrelated business income.

CHH-DEV, MRS, TSM, MHN, MHV and VFS are organizations subject to federal and/or state income taxes. SMMM and SMH are treated as single member LLC's for tax purposes. Occumed and TGSC are treated as partnerships for tax purposes.

Management annually reviews its tax provisions and has determined that there are no material uncertain tax positions that require recognition in the consolidated financial statements at September 30, 2019 and 2018.

Health Insurance Benefits

The System self-insures its employee health insurance coverages and accrues the estimated costs of incurred and reported and incurred but not reported claims, after consideration of its individual and aggregate stop-loss insurance coverages, based upon data provided by the third-party administrators of the programs and its historical claims experience.

Reclassifications

Certain reclassifications were made to the 2018 consolidated financial statements to conform with the 2019 presentation.

New Accounting Standards Adopted

Revenue Recognition

In 2019, the System adopted FASB Accounting Standards Update (ASU) No. 2014-09, *Revenue from Contracts with Customers (Topic 606)*. ASU No. 2014-09 supersedes the revenue recognition requirements in Topic 605, *Revenue Recognition,* and most industry specific guidance. The core principle under ASU No. 2014-09 is that revenues are recognized to depict the transfer of promised goods or services to customers (patients) in an amount that reflects the consideration at which the entity expects to be entitled in exchange for those goods or services. Additionally, ASU No. 2014-09 requires enhanced disclosures of revenue arrangements.

The System applied the modified retrospective approach to all contracts when adopting ASU No. 2014-09. As a result of the adoption, what was previously classified as the provision for bad debts in the consolicated statements of operations is now reflected as implicit price concessions, as defined in Topic 606, and therefore included as a reduction of net patient service revenues. For changes in transaction price related to changes in patient circumstances, the System will prospectively recognize those amounts as a provision for bad debts within operating expenses on the consolidated statements of operations. For periods prior to October 1, 2018, the provision for bad debts has been presented consistent with the previous revenue recognition standards that required separate presentation of these amounts as a component of net patient service revenue. Additionally, as a result of the adoption of ASU No. 2014-09, the allowance for doubtful accounts of approx mately $71,460,000 as of October 1, 2018 became a component of patient accounts receivable.

Not-for-Profit Financial Statement Presentation

In 2019, the System adopted FASB ASU No. 2016-14, *Not-for-Profit Entities (Topic 958): Presentation of Financial Statements of Not-for-Profit Entities*. ASU No. 2016-14 addresses the complexity and understandability of net asset classification, deficiencies in information about liquidity and availability of resources, and the lack of consistency in the type of information provided about expenses and investment return. The System has adjusted the presentation of these consolidated financial statements accordingly. ASU No. 2016-14 has been applied retrospectively to all periods presented, except for the disclosure of functional expenses by nature and function. This disclosure has been presented for 2019 only, as permitted by ASU No. 2016-14.

The new standard changes the following aspects of the consolidated financial statements:

- Unrestricted net assets have been renamed Net Assets Without Donor Restrictions;
- Temporarily restricted net assets have been renamed Net Assets With Donor Restrictions;
- The consolidated financial statements include a disclosure about liquidity and availability of resources (Note 18);
- The functional expense disclosure for 2019 includes expenses reported by both nature and function (Note 19).

New Accounting Standards Not Yet Adopted

Pension Plans

In March 2017, the FASB issued ASU No. 2017-07, *Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost.* ASU No. 2017-07 was issued to provide guidance on the presentation of net periodic pension and net periodic postretirement benefit cost in the statements of operations and the components that are eligible for capitalization in assets. ASU No. 2017-07 requires that an employer report the service cost component of net periodic pension and net periodic postretirement benefit cost in the same line item used to record compensation expense for the related employees during the period. The other components are required to be presented in the statements of operations separately from the service cost component and outside a subtotal of income from operations, if one is presented. The System will be required to retrospectively adopt the guidance in ASU No. 2017-07 for its year ending September 30, 2020.

In August 2018, the FASB issued ASU No. 2018-14, *Disclosure Framework - Changes to the Disclosure Requirements for Defined Benefit Plans.* ASU No. 2018-14 modifies and clarifies the disclosure requirements for employers that sponsor defined benefit pension and other postretirement plans. These amendments remove disclosures that are no longer considered cost beneficial, clarify the specific requirements of disclosures, and add disclosure requirements identified as relevant. The System will be required to retrospectively adopt the guidance in ASU No. 2018-14 for its year ending September 30, 2023; early adoption is permitted.

Leases

In February 2016, the FASB issued ASU No. 2016-02, *Leases (Topic 842).* ASU No. 2016-02 was issued to increase transparency and comparability among organizations by recognizing lease assets and lease liabilities on the balance sheets and disclosing key information about leasing arrangements. Under the provisions of ASU No. 2016-02, a lessee is required to recognize a right-to-use asset and lease liability, initially measured at the present value of the lease payments, in the balance sheets. In addition, lessees are required to provide qualitative and quantitative disclosures that enable users to understand more about the nature of the System's leasing activities. The System will be required to retrospectively adopt the guidance in ASU No. 2016-02 for its year ending September 30, 2020.

Restricted Cash

In November 2016, the FASB issued ASU No. 2016-18, *Statement of Cash Flows (Topic 230), Restricted Cash.* ASU No. 2016-18 requires that a statement of cash flows explain the change during the period in the total cash, cash equivalents, and amounts generally described as restricted cash or restricted cash equivalents. Amounts generally described as restricted cash and restricted cash equivalents should be included with cash and cash equivalents when reconciling the beginning-of-period and end-of-period total amounts showing on the statement of cash flows. The System will be required to retrospectively adopt the guidance in ASU No. 2016-18 for its year ending September 30, 2020.

The System is currently assessing the effects that the adoption of the above standards will have on their consolidated financial statements.

3. Acquisition

Effective May 1, 2018, CHHI acquired the assets of SMMC and its subsidiaries (SMMM, SMMCF, and VFS). The overall purpose of this merger was the creation of a single hospital system in Huntington, WV with two campuses. The System seeks to improve the health of residents of western WV, eastern Kentucky and southern Ohio and surrounding area through the delivery of quality, cost-effective health care services. It is anticipated that the formation of a single system in the area will allow for (1) development of synergies in service delivery; (2) improved access to quality and technologically advanced health care services; (3) enhanced recruitment of health professionals and development of resources for expanded programs; (4) cost efficiencies, capital and other cost savings; (5) better access to capital for support services enhancements, (6) enhanced training programs for allied health professionals and graduated medical education; and (7) renewed focus on community health.

The purchase price was based upon the agreed-upon sale price between CHHI and the sellers. This sales price was negotiated in 2014, and due to regulatory approval and other legal setbacks, closing on this transaction did not take place until 2018. The provisions of the affiliation and acquisition were absent of any significant contingency payments, options, or commitments.

The System incurred nonrecurring acquisition costs since 2014 related to this acquisition; such costs have been expensed as incurred. Acquisition costs incurred during 2019, as reflected in the consolidated statements of operations, totaled $531,071. Acquisition costs incurred during 2018, as reflected in the consolidated statements of operations, totaled $4,169,246.

Assets acquired and liabilities assumed in the acquisition were recorded in the consolidated financial statements as of the acquisition date based upon their estimated fair values. The System recorded inherent contributions totaling $29,682,423 in 2018, which represents the excess of the net acquisition date fair value of assets acquired and liabilities assumed over the aggregate consideration transferred and the fair value of noncontrolling interest in the acquiree. Such inherent contributions are reported in the consolidated statements of operations and changes in net assets as inherent contribution in acquisition of St. Mary's Medical Center. These inherent contributions increased the performance indicator by $27,528,609 and increased net assets with donor restrictions by $2,153,814 in 2018.

The purchase price and assumed debt was financed with proceeds of an interim bridge loan, which was then refinanced during 2018 with proceeds from the issuance of the 2018 Series Bonds (Note 11). As part of this transaction, the Corporation also assumed certain operating leases in effect, of which approximately $3,892,000 was expensed during 2018. The future maturities of these leases are included in the amounts disclosed in Note 16.

Consideration consisted of cash payments totaling $106,473,577 and fair value of noncontrolling interest in acquiree of $941,152. No goodwill or other intangible assets were recognized as a result of this acquisition. Net assets without donor restrictions are recognized as inherent contribution from acquisition of St. Mary's Medical Center in the consolidated statements of operations and changes in net assets, and are included in revenues in excess of expenses.

The fair value of assets acquired and liabilities assumed at May 1, 2018 were as follows:

	Net Assets Without Donor Restrictions	Net Assets With Donor Restrictions	Total
Assets:			
Cash and cash equivalents	$ 7,912,463	$ 664,241	$ 8,576,704
Accounts receivable:			
Patients, net	65,045,766	-	65,045,766
Other	16,314,505	-	16,314,505
Inventories	10,375,679	-	10,375,679
Prepaid expenses and other current assets	4,534,012	-	4,534,012
Assets limited as to use, trustee held funds	2,842,667	-	2,842,667
Investments:			
Board designated	85,209,977	-	85,209,977
Externally designated	4,273,853	1,489,573	5,763,426
Property and equipment	197,464,480	-	197,464,480
Other assets	10,427,545	-	10,427,545
Total assets	404,400,947	2,153,814	406,554,761
Less liabilities assumed:			
Current and long-term debt	(68,773,961)	-	(68,773,961)
Accounts payable and accrued expenses	(48,542,703)	-	(48,542,703)
Estimated third-party payor settlements	(374,932)	-	(374,932)
Pension liability (net of plan assets, Note 13)	(132,425,875)	-	(132,425,875)
Derivative financial instruments	(3,974,037)	-	(3,974,037)
Other (current and long-term)	(15,366,101)	-	(15,366,101)
Total liabilities	(269,457,609)	-	(269,457,609)
Net	134,943,338	2,153,814	137,097,152
Consideration transferred	107,414,729	-	107,414,729
Inherent contribution	$ 27,528,609	$ 2,153,814	$ 29,682,423

The results of operations of these entities have been included in the consolidated statements of operations and changes in net assets since the acquisition date. Certain financial information related to these entities from the date of acquisition through September 30, 2018 are as follows:

Operating revenues	$ 184,015,569
Revenues in excess of expenses	$ 24,762,838
Increase in net assets:	
Net assets without donor restrictions	$ 38,798,225
Net assets with donor restrictions	1,946,808
Total	$ 40,745,033

The following table presents certain pro-forma financial information for the year ending September 30, 2018 to reflect consolidated revenues, the performance indicator and changes in net assets (by class) as if this merger had taken place effective October 1, 2017:

Operating revenues	$ 1,059,954,106
Revenues in excess of expenses	$ 71,923,873
Increase in net assets:	
Net assets without donor restrictions	$ 106,273,512
Net assets with donor restrictions	2,449,426
Total	$ 108,722,938

4. Edwards Comprehensive Cancer Center

The Edwards Foundation was established in 2002 as a supporting nonprofit organization to CHHI and the Marshall University School of Medicine through a $16,000,000 endowment funded by James F. Edwards and Joan C. Edwards. The members of the Edwards Foundation include representatives of CHHI, the Marshall University School of Medicine, and designees selected by the Edwards family.

In September 2003, CHHI and the Edwards Foundation executed a 99-year ground lease whereby the Edwards Foundation leases land from CHHI for $1 per year. During the year ended September 30, 2005, the Edwards Foundation commenced construction of the Edwards Comprehensive Cancer Center (ECCC) on the campus of CHHI pursuant to the ground lease.

In January 2006, CHHI and the Edwards Foundation executed a 97-year lease whereby CHHI leases the building and associated equipment for the purpose of operating the ECCC. During the term of the building and equipment lease, CHHI is required to make annual lease payments to the Edwards Foundation in an amount equal to the sum of $12 per year plus 50 percent of annual net profit, as defined in the lease agreement, generated by the operations of the ECCC. Additionally, the Edwards Foundation obtained a bank loan to finance a portion of the construction costs and equipment. As long as any portion of the loan, or any extensions or renewals thereof, remains outstanding, CHHI shall make annual lease payments up to 100 percent of the amount necessary to amortize the loan over a period of 15 years, as defined in the lease agreement. The loan had a balance of $3,355,000 at September 30, 2019 and matures in August 2021. The loan is secured by the property and equipment of the ECCC.

Under the ground lease, the title to the building and equipment associated with the ECCC will transfer to CHHI and perfect upon the expiration or early termination of the lease. The Edwards Foundation completed construction and equipping of the ECCC in 2006 at a total cost of approximately $31,605,000. This amount, net of accumulated amortization, is classified in property and equipment in the consolidated balance sheets (Note 9).

The building and equipment related to the ECCC are being amortized over their estimated useful lives, which is included in depreciation and amortization in the consolidated statements of operations (Note 9). Additionally, any rent payment due under the terms of the building and equipment lease is recorded as rental expense, which approximated $3,763,000 in 2019 and $5,352,000 in 2018, and is included in other expenses in the consolidated statements of operations.

5. Charity Care

The System estimates the cost of providing charity care using the ratio of average patient care cost to gross charges and then applies that ratio to the gross uncompensated charges associated with providing charity care. The amount of charges forgone for services and supplies furnished under the System's charity care policies follows for the years ended September 30:

	2019	2018
Charges forgone, based on established rates	$ 20,222,000	$ 14,543,000
Management's estimate of expenses incurred to provide charity care	$ 6,394,000	$ 4,677,000
Equivalent percentage of charity care services to gross patient service revenues, based on established rates	0.6 %	0.6 %

6. Net Patient Service Revenues

The System has agreements with third-party payors that provide for payments to the System at amounts different from its established rates. A significant portion of the System's net patient service revenues are derived from these third-party payor programs. The following summarizes the significant payment arrangements with major third-party payors:

Medicare

Inpatient acute care services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Outpatient services are paid primarily at prospectively determined rates. The System receives additional reimbursement for disproportionate share based on the level of Medicaid and Supplementary Security Income patients it serves. The System also receives payments for direct and indirect medical education from the Medicare program.

The System's classification of patients under the Medicare program and the appropriateness of their admission are subject to an independent review by a Medicare quality improvement organization. The System's cost reports have been audited by the Medicare fiscal intermediary through September 30, 2013. Revenue from Medicare was 38 percent in 2019 and 35 percent in 2018 of total net patient service revenues.

Medicaid

Payments for inpatient acute care services rendered to Medicaid program beneficiaries are based primarily upon a prospectively determined rate per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Outpatient services are paid on a published fee schedule. Revenue from Medicaid was 15 percent in 2019 and 2018 of total net patient service revenues.

The State of West Virginia's Disproportionate Share Hospital (DSH) State Plan reimburses hospitals in the state that provide Medicaid services and meet other eligibility criteria. Under the DSH program, the System received approximately $15,435,000 in 2019 and $14,817,000 in 2018, which is included in net patient service revenues in the consolidated statements of operations.

The DSH State Plan was amended to provide for a settlement process among participating hospitals. Beginning with 2011, the state is completing a final settlement and redistribution process. In early 2019, the audits for 2011, 2012, and 2013 were finalized and funding was redistributed based on those audits. The Bureau for Medical Services of the State of West Virginia Department of Health and Human Resources has contracted with a third-party vendor to assist with the audit settlement process for the DSH State Plan. The laws and regulations governing the DSH settlement process are complex, involving statistical data from all participating hospitals, and subject to interpretation. Accordingly, the System is not able to estimate the possible loss or gain that could arise upon completion of the DSH settlement process. The results of the resolution of the settlement process could materially impact the System's future results of operations or cash flows in a particular period.

The State of West Virginia increases Medicaid reimbursement to qualified public safety net hospitals for services to Medicaid-eligible patients. Supplemental payments may be received in an amount up to the difference between current reimbursement and the maximum permissible payments under DPP (formerly known as UPL) regulations. The first payment was made in August 2012 and periodic payments have been made subsequent to that date. Additionally, in 2016 a supplemental program was introduced to include the Medicaid expansion beneficiaries known as the Bridge population.

The DPP payments are recorded in the period they are received. Under the DPP program, the System received payments of approximately $41,977,000 in 2019 and $24,964,000 in 2018, which is included in net patient service revenues in the consolidated statements of operations.

The laws and regulations governing the DPP program are complex and subject to interpretation. The DPP reimbursement is funded by a portion of the Medicaid Provider Tax (Note 2). There is risk that Congress may change federal policy in the future in a way that might limit or eliminate the DPP payments but maintain the Medicaid Provider Tax.

Blue Cross

Inpatient and outpatient services rendered to Blue Cross subscribers are paid at either prospectively determined rates per case or discounts from established charges. Revenue from Blue Cross was 23 percent in 2019 and 29 percent in 2018 of total net patient service revenues.

Other Payors

The System has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to the System under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

Health Care Authority

Effective June 5, 2016, legislation was enacted that eliminated the rate setting powers of the Health Care Authority (HCA). However, the HCA was given the power to review, approve and regulate cooperative agreements between qualified hospitals that are members of academic medical centers and one or more other hospitals or other health care providers. The System is subject to the regulatory powers of the HCA as part of the cooperative agreement entered into as part of the acquisition. Those regulatory powers include annual reporting requirements, rate setting controls, and the authority to order rebates for failure to meet quality metrics or consumer price increase targets.

Laws and regulations concerning government programs, including Medicare and Medicaid, are complex and subject to varying interpretation. As a result of investigations by governmental agencies, various health care organizations have received requests for information and notices regarding alleged noncompliance with those laws and regulations, which, in some instances, have resulted in organizations entering into significant settlement agreements. Compliance with such laws and regulations may also be subject to future government review and interpretation as well as significant regulatory action, including fines, penalties, and potential exclusion from the related programs. There can be no assurance that regulatory authorities will not challenge the System's compliance with these laws and regulations, and it is not possible to determine the impact (if any) such claims or penalties would have upon the System. In addition, the contracts the System has with commercial payors also provide for retroactive audit and review of claims.

Settlements with third-party payors for retroactive adjustments due to audits, reviews or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence with the payor and the System's historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known (that is, new information becomes available), or as years are settled or no longer subject to such audits, reviews and investigations. Adjustments arising from a change in the transaction price were not significant in 2019 or 2018.

Generally, patients who are covered by third-party payors are responsible for related deductibles and coinsurance, which vary in amount. The System also provides services to uninsured patients, and offers those uninsured or underinsured patients a discount, either by policy or law, from standard charges. The System estimates the transaction price for patients with deductibles and coinsurance and from those who are uninsured based on historical experience and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charges by any contractual adjustment, discounts, and implicit price concessions. Subsequent changes to the estimate of the transaction price are generally recorded as an adjustment to net patient service revenues in the period of the change. For the year ended September 30, 2019, the impact of changes in estimates of implicit price concessions, discounts and contractual adjustments used to determine the transaction price was not material to the current period. Subsequent changes that are determined to be the result of an adverse change in the patient's ability to pay are recorded as bad debt expense.

Consistent with the System's mission, care is provided to patients regardless of their ability to pay. Therefore, the System has determined it has provided implicit price concessions to uninsured patients and other patient balances (for example, copays and deductibles). The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amounts the System expects to collect based on its collection history with those patients.

The System disaggregates revenue from contracts with customers by payor source and type of service as this depicts the nature, amount, timing and uncertainty of its revenue and cash flows as affected by economic factors. The following tables provide details of these factors.

Net patient service revenues disaggregated by primary payor for the year ended September 30, 2019 are as follows:

Medicare	$ 397,636,556
Medicaid	153,929,790
Blue Cross	236,445,983
Commercial/HMO/Other	232,054,948
Patients	28,911,710
Total	$ 1,048,978,987

Revenue from patient's deductibles and coinsurance are included in the categories presented above based on the primary payor.

Net patient service revenues disaggregated by type of service for the year ended September 30, 2019 are as follows:

Inpatient	$ 451,864,495
Outpatient	597,114,492
Total	$ 1,048,978,987

7. Investments

The composition of investments at September 30 is as follows:

	2019	2018
Cash and cash equivalents	$ 47,726,218	$ 92,109,286
Marketable equity securities	164,131,185	162,844,401
U.S. government and agency obligations	42,657,628	43,195,874
Corporate bonds	33,876,295	30,635,914
Mutual funds, fixed income	21,228,290	20,037,911
Total	$ 309,619,616	$ 348,823,386

Investment income, gains, and losses included in net assets without donor restrictions are as follows:

	2019	2018
Interest and dividend income	$ 10,891,485	$ 6,076,092
Change in net unrealized (losses) gains on trading securities	(1,766,501)	7,157,194
Net realized gains on sales of securities	4,886,237	4,876,835
Investment manager and trustee fees	(1,130,035)	(746,048)
Net investment income	$ 12,881,186	$ 17,364,073

8. Fair Value Measurements and Financial Instruments

The System measures its investments and derivative financial instruments on a recurring basis in accordance with accounting principles generally accepted in the United States of America. The framework for measuring fair value includes a hierarchy used to classify the inputs used in measuring fair value. The hierarchy prioritizes the inputs used in determining valuations into three levels. The level in the fair value hierarchy within which the fair value measurement falls is determined based on the lowest level input that is significant to the fair value measurement.

The levels of the fair value hierarchy are as follows:

Level 1 - Fair value is based on unadjusted quoted prices in active markets for identical assets or liabilities. These generally provide the most reliable evidence and are used to measure fair value whenever available.

Level 2 - Fair value is based on significant inputs, other than Level 1 inputs, that are observable either directly or indirectly for substantially the same term of the asset or liability through corroboration with observable market data. Level 2 inputs include quoted market prices in active markets for similar assets, quoted market prices in markets that are not active for identical or similar assets, and other observable inputs.

Level 3 - Fair value is based on significant unobservable inputs. Examples of valuation methodologies that would result in Level 3 classification include option pricing models, discounted cash flows, and other similar techniques.

The fair value of financial instruments listed below was determined using the following valuation hierarchy at September 30, 2019:

	Carrying Value	Fair Value	Quoted Prices In Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)
Assets, Recurring Fair Value Measurements					
Investments:					
Cash and cash equivalents	$ 47,726,218	$ 47,726,218	$ 47,726,218	$ -	$ -
Marketable equity securities:					-
Consumer discretionary	16,624,517	16,624,517	16,624,517	-	-
Consumer staples	11,210,208	11,210,208	11,210,208	-	-
Energy	8,102,711	8,102,711	8,102,711	-	-
Financials	24,763,651	24,763,651	24,763,651	-	-
Healthcare	24,975,041	24,975,041	24,975,041	-	-
Industrials	15,555,918	15,555,918	15,555,918	-	-
Information technology	27,530,614	27,530,614	27,530,614	-	-
Materials	5,328,668	5,328,668	5,328,668	-	-
Other	13,570,865	13,570,865	13,570,865	-	-
Real estate	209,866	209,866	209,866	-	-
Telecommunications	12,779,765	12,779,765	12,779,765	-	-
Utilities	3,479,361	3,479,361	3,479,361	-	-
U.S. government and agency obligations	42,657,628	42,657,628	-	42,657,628	-
Corporate bonds	33,876,295	33,876,295	-	33,876,295	-
Mutual funds, fixed income	21,228,290	21,228,290	21,228,290	-	-
Total investments	$ 309,619,616	$ 309,619,616	$ 233,085,693	$ 76,533,923	$ -
Liabilities, Recurring Fair Value Measurements					
Derivative financial instruments	$ 12,671,446	$ 12,671,446	$ -	$ 12,671,446	$ -
Assets Disclosed at Fair Value					
Cash and cash equivalents	$ 202,032,591	$ 202,032,591	$ 202,032,591	$ -	$ -
Pledges receivable	1,587,966	1,587,966	-	-	1,587,966
Total	$ 203,620,557	$ 203,620,557	$ 202,032,591	$ -	$ 1,587,966
Liabilities Disclosed at Fair Value					
Bonds payable	$ 355,197,448	$ 384,003,792	$ -	$ 384,003,792	$ -
Other notes payable	1,231,760	1,231,760	-	-	1,231,760
Total	$ 356,429,208	$ 385,235,552	$ -	$ 384,003,792	$ 1,231,760

The fair value of financial instruments listed below was determined using the following valuation hierarchy at September 30, 2018:

	Carrying Value	Fair Value	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)
Assets, Recurring Fair Value Measurements					
Investments:					
Cash and cash equivalents	$ 92,109,286	$ 92,109,286	$ 92,109,286	$ -	$ -
Marketable equity securities:					
Consumer discretionary	14,459,933	14,459,933	14,459,933	-	-
Consumer staples	6,609,550	6,609,550	6,609,550	-	-
Energy	12,042,033	12,042,033	12,042,033	-	-
Financials	20,843,525	20,843,525	20,843,525	-	-
Healthcare	26,602,599	26,602,599	26,602,599	-	-
Industrials	14,597,048	14,597,048	14,597,048	-	-
Information technology	26,392,205	26,392,205	26,392,205	-	-
Materials	5,312,767	5,312,767	5,312,767	-	-
Other	20,386,971	20,386,971	20,386,971	-	-
Real estate	1,030,514	1,030,514	1,030,514	-	-
Telecommunications	11,520,197	11,520,197	11,520,197	-	-
Utilities	3,047,059	3,047,059	3,047,059	-	-
U.S. government and agency obligations	43,195,874	43,195,874	-	43,195,874	-
Corporate bonds	30,635,914	30,635,914	-	30,635,914	-
Mutual funds, fixed income	20,037,911	20,037,911	20,037,911	-	-
Total investments	$ 348,823,386	$ 348,823,386	$ 274,991,598	$ 73,831,788	$ -
Liabilities, Recurring Fair Value Measurements					
Derivative financial instruments	$ 7,535,120	$ 7,535,120	$ -	$ 7,535,120	$ -
Assets Disclosed at Fair Value					
Cash and cash equivalents	$ 142,785,484	$ 142,785,484	$ 142,785,484	$ -	$ -
Pledges receivable	947,733	947,733	-	-	947,733
Total	$ 143,733,217	$ 143,733,217	$ 142,785,484	$ -	$ 947,733
Liabilities Disclosed at Fair Value:					
Bonds payable	$ 359,086,344	$ 363,032,276	$ -	$ 363,032,276	$ -
Other notes payable	1,992,858	1,992,858	-	-	1,992,858
Total	$ 361,079,202	$ 365,025,134	$ -	$ 363,032,276	$ 1,992,858

The following is a description of the valuation methodologies used for assets and liabilities measured at fair value and for financial instruments disclosed at fair value. There have been no changes in methodologies used at September 30, 2019 and 2018.

Cash and cash equivalents: The carrying amounts approximate fair value because of the short maturity of these financial instruments.

Marketable equity securities: Valued at the closing price reported on the active market on which the individual securities are traded.

Corporate bonds and U.S. government and agency obligations: Valued based on spreads of published interest rate curves.

Mutual funds: Valued at the quoted net asset value of shares (basis for trade) held by the System at year end.

Pledges receivable: Valued based on the original pledge amount, adjusted by a discount rate that a market participant would demand and an evaluation for uncollectible pledges.

Long-term debt: Valued based on current rates offered for similar issues with similar securities terms and maturities, or estimated using a discount rate that a market participant would demand.

Derivative financial instruments: Valued based on proprietary models of an independent third party valuation specialist. The fair value takes into consideration the prevailing interest rate environment and the specific terms and conditions of the derivative financial instruments and was estimated using the zero-coupon discounting method. This method calculates the future payments required by the derivative financial instruments, assuming that the current forward rates implied by the yield curve are the market's best estimate of future spot interest rates. These payments are then discounted using the spot rates implied by the current yield curve for a hypothetical zero-coupon rate bond due on the date of each future net settlement payment on the derivative financial instruments. The value represents the estimated exit price the System would pay to terminate the agreements. The change in fair value of derivative financial instruments is included in revenues in excess of expenses.

It is not practicable to estimate the fair value of amounts due to or from related parties since terms could not be duplicated in the market and related parties can revise terms, making assumptions supporting fair values potentially unreliable.

The preceding methods described may produce a fair value calculation that may not be indicative of the net realizable value or reflective of future fair values. Furthermore, although the System believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

9. Property and Equipment

Property and equipment and related accumulated depreciation consist of the following at September 30:

	2019	2018
Land and land improvements	$ 29,326,495	$ 29,242,268
Buildings and fixed equipment	479,840,406	463,737,515
Major movable equipment	236,377,395	225,389,270
Buildings and equipment under long-term lease with related party (Note 4)	31,604,714	31,604,714
Total	777,149,010	749,973,767
Less accumulated depreciation and amortization	350,767,485	320,349,942
	426,381,525	429,623,825
Construction in progress	23,065,230	14,143,044
Property and equipment, net	$ 449,446,755	$ 443,766,869

Accumulated amortization on buildings and equipment under long-term lease with related party approximates $22,224,000 at September 30, 2019 and $16,898,000 at September 30, 2018.

Construction in progress consists primarily of renovation and expansion projects and a system-wide information technology upgrade. Purchase commitments related to these and other miscellaneous projects were approximately $16,333,000 at September 30, 2019.

In November 2018, CHHI entered into an agreement with a vendor for a system-wide information technology upgrade. The contract has a build cost budget of approximately $27,686,000, as well as ongoing support and maintenance fees of approximately $11,655,000 through November 2024. Build costs of approximately $19,474,000 were incurred through September 30, 2019.

10. Lines of Credit

CHHI maintains a $5,000,000 unsecured revolving loan agreement, maturing March 14, 2020. There were no borrowings outstanding at September 30, 2019 and 2018. Borrowings under the agreement bear interest at one-month LIBOR plus 1.75 percent per annum (3.67 percent at September 30, 2019).

SMMC maintains a margin account (revolving line of credit) with a national investment banking firm that allows them to borrow against the value of investments held in trust by the firm for the benefit of SMMC. There were no borrowings outstanding at September 30, 2019 and 2018.

Occumed has a $401,524 revolving loan agreement. Borrowings under the agreement were $357,196 at September 30, 2019 and $361,344 at September 30, 2018. Borrowings under the agreement bear interest at 4.75 percent per annum. Under the terms of the agreement, the amounts borrowed are due and payable on January 10, 2020, and interest is payable monthly. The revolving loan agreement is guaranteed by the members of Occumed.

TGSC maintains a $500,000 revolving line of credit, due on demand. Borrowings under the agreement were $70,000 at September 30, 2019. There were no borrowings outstanding at September 30, 2018. Borrowings under the agreement bear interest at the prime rate (5.00 percent at September 30, 2019), and interest is payable monthly.

11. Long-Term Debt

Long-term debt consists of the following at September 30:

	2019	2018
Refunding and improvement revenue bonds - 2018 Series A and B	$ 271,575,000	$ 271,575,000
Revenue refunding bonds - 2008 Series A and B	72,210,000	75,720,000
Capital leases and other notes payable	5,833,321	2,140,809
Total	349,618,321	349,435,809
Debt issuance costs	(3,671,732)	(3,827,661)
Net unaccreted bond premium (discount)	15,084,180	15,619,005
Current maturities of long-term debt	(8,134,776)	(4,830,118)
Long-term debt	$ 352,895,993	$ 356,397,035

The scheduled principal repayments as of September 30, 2019 are as follows:

Years ending September 30:	
2020	$ 8,134,776
2021	7,695,031
2022	7,500,389
2023	7,735,099
2024	7,998,026
Thereafter	310,555,000
Total	$ 349,618,321

Obligated Group

The Obligated Group consists of CHHI and SMMC. Both members of the Obligated Group are jointly and severally liable for all outstanding obligations of the Obligated Group. Payments of principal and interest are collateralized by a pledge of gross receipts and funds of the Obligated Group.

The System's indebtedness agreements contain restrictive covenants, the most significant of which are the maintenance of minimum debt service coverage and restrictions as to the incurrence of additional indebtedness and transfers of assets.

2018 Series, Hospital Refunding and Improvement Revenue Bonds

In September 2018, the West Virginia Hospital Finance Authority (the Authority) issued $240,300,000 of Hospital Refunding and Improvement Revenue Bonds 2018 Series A and $31,275,000 of Hospital Improvement Revenue Bonds 2018 Series B (Taxable) (the 2018 Bonds) on behalf of the Obligated Group. The proceeds of the 2018 Bonds were used to finance the SMMC acquisition by repaying bridge loans incurred at closing; finance costs incurred in connection with the SMMC acquisition that were not previously paid or reimbursed from the bridge loans; refund the CHHI Series 2009 Bonds; finance future capital improvements; and pay for the costs of issuance.

The 2018 Bonds include fixed rate serial bonds of $101,055,000 maturing in 2020 through 2038 with interest rates ranging from 4 percent to 5 percent; and fixed rate term bonds of $170,520,000 maturing in 2043, 2047, and 2048 with interest rates ranging from 4.125 percent to 5.132 percent.

2008 Series, Hospital Revenue Improvement Bonds

In October 2008, the Authority issued $48,480,000 of Hospital Revenue Refunding Bonds 2008 Series A and $48,475,000 of Hospital Revenue Refunding Bonds 2008 Series B (the 2008 Bonds) on behalf of CHHI. The 2008 Bonds are repayable through January 1, 2034, and bear interest based on a weekly rate model (1.59 percent at September 30, 2019). The 2008 Bonds are secured by a bank letter-of-credit agreement with Branch Banking and Trust Company (BB&T) that will provide financing in an amount necessary to purchase a portion of the 2008 Bonds if not remarketed, with repayment terms on a long-term basis. The bank letter-of-credit agreement will expire on October 17, 2021.

Capital Leases and Other Notes Payable

Capital leases and other notes payable consist of capital leases, bank loan agreements, and notes payable from individuals, which are secured by equipment and property with various maturity dates through 2024 and require month y principal and interest payments.

12. Derivative Financial Instruments

The System has two interest rate swap agreements to manage its exposure on its debt instruments. During the term of these agreements, the fixed rate swaps convert variable rate debt to a fixed rate. The notional amount under each interest rate swap is reduced over the term of the respective agreement to correspond with reductions in the outstanding bond series.

The following table summarizes the System's interest rate swap agreements:

Swap Type	Expiration Date	System Receives	System Pays	Notional Amounts at September 30, 2019
Floating to fixed	2034	62.2% one-month LIBOR	3.68 %	$ 37,800,000
Floating to fixed	2034	64.8% one-month LIBOR	3.48	37,825,000
				$ 75,625,000

By using derivative financial instruments to manage these risks, the System exposes itself to credit risk and market risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contracts. When the fair value of a derivative contract is positive, the counterparty owes the System, which creates credit exposure for the System. When the fair value of a derivative contract is negative, the System owes the counterparty. If the System has a derivative in a liability position, the credit-adjusted market values could be adjusted downward. Market risk is the effect on the value of a financial instrument that results from a change in interest rates. The market risk associated with interest rate changes is managed by establishing and monitoring parameters that limit the types and degree of market risk that may be undertaken. Management also mitigates risk through periodic reviews of its derivative positions in the context of its total blended cost of capital.

The fair value of the interest rate swap agreements was $12,671,446 at September 30, 2019 and $7,535,120 at September 30, 2018. The net cash paid or received under the swap agreements is recognized as an adjustment to interest expense. As a result of the swap agreements, interest expense increased by approximately $1,340,000 in 2019 and $1,749,000 in 2018.

In 2018, the System terminated the interest rate swap agreements assumed in the SMMC acquisition (Note 3). The System paid a final cash settlement of $3,785,000, which included a loss on settlement of approximately $165,000, and is included in change in fair value of derivative financial instruments in the consolidated statements of operations.

13. Benefit Plans

CHHI has a defined contribution 401(k) retirement plan covering substantially all of their employees. The plan became effective January 1, 2011. Eligibility requires one year of service with 1,080 hours worked. CHHI contributes 3 percent of eligible salary annually, and employees vest in employer contributions after five years of service. Total expenses relating to this plan were approximately $5,183,000 in 2019 and $4,981,000 in 2018.

SMMC has a defined contribution 403(b) retirement plan covering substantially all of their employees. The plan, which became effective January 1, 2011, has two components consisting of a salary reduction portion and a discretionary contribution portion. The salary reduction component allows eligible employees to contribute, as a salary deferral, to the plan. The discretionary contribution portion of the plan allows for additional contributions of eligible wages subject to certain limitations and restrictions. Total expenses relating to this plan were approximately $4,029,000 in 2019 and $1,289,000 in 2018.

The System sponsors noncontributory defined benefit plans covering substantially all eligible employees. Pension benefits to participating employees are based on years of credited service and salaries. The System provides funding sufficient to meet minimum funding requirements under applicable federal laws. Plan assets, primarily consisting of U.S. government and equity securities, are held in trust.

- Benefit accruals under the CHHI nonunion retirement plan were frozen effective September 30, 2015.
- Benefit accruals under the CHHI union retirement plan were frozen effective November 2, 2016.
- Benefit accruals under the SMMC retirement plan were frozen effective August 1, 2010.

In addition, CHHI sponsors a postretirement health benefit plan for its employees who have at least 17 years of service and who retire at age 62 or older. Entrance into the postretirement plan became frozen to new employees and restricted to existing employees effective November 2, 2016.

The following table presents a reconciliation of the beginning and ending balances of the various plans' projected benefit obligations and the fair value of plan assets and funded status of the plans measured at September 30:

	Pension Plans		Postretirement Plan	
	2019	2018	2019	2018
Changes in projected benefit obligation:				
Projected benefit obligation, beginning of year	$ 539,344,224	$ 322,008,714	$ 49,156,607	$ 47,279,096
SMMC acquisition (Note 3)	-	240,830,813	-	-
Service cost	-	-	1,299,074	1,353,954
Interest cost	21,970,908	16,841,562	2,145,338	1,936,086
Actuarial loss (gain)	55,441,988	(27,619,130)	13,995,549	(59,977)
Benefits paid	(17,569,158)	(12,717,734)	(1,689,848)	(1,352,552)
Projected benefit obligation, end of year	$ 599,187,962	$ 539,344,225	$ 64,906,720	$ 49,156,607
Changes in plan assets:				
Fair value of plan assets, beginning of year	$ 357,139,352	$ 233,460,275	$ -	$ -
SMMC acquisition (Note 3)	-	108,404,938	-	-
Actual return on plan assets	12,354,077	24,193,997	-	-
Employer contributions	3,812,905	3,797,876	1,689,848	1,352,552
Benefits paid	(17,569,158)	(12,717,734)	(1,689,848)	(1,352,552)
Fair value of plan assets, end of year	$ 355,737,176	$ 357,139,352	$ -	$ -
Funded status at end of year	$ (243,450,786)	$ (182,204,873)	$ (64,906,720)	$ (49,156,607)

The following table is a reconciliation of the funded status at end of year to the amounts recognized in the consolidated balance sheets at September 30:

	Pension Plans		Postretirement Plan	
	2019	2018	2019	2018
Accrued expenses	$ -	$ -	$ 1,849,803	$ 1,694,757
Accrued pension and postretirement liabilities	243,450,786	182,204,873	63,056,917	47,461,850
Total	$ 243,450,786	$ 182,204,873	$ 64,906,720	$ 49,156,607

The accumulated benefit obligation of the pension plans was $599,187,962 at September 30, 2019 and $539,344,225 at September 30, 2018.

The following table sets forth the components of net periodic benefit (credit) expense in 2019 and 2018:

	Pension Plans		Postretirement Plan	
	2019	2018	2019	2018
Service cost	$ -	$ -	$ 1,299,074	$ 1,353,954
Interest cost	21,970,908	16,841,562	2,145,338	1,936,086
Expected return on plan assets	(25,166,635)	(20,192,131)	-	-
Recognized net actuarial loss	125,643	1,606,497	-	-
Amortization of prior service credit	-	-	(772,031)	(772,031)
Amortization of losses	-	-	1,364,813	1,494,178
Net periodic benefit (credit) expense	$ (3,070,084)	$ (1,744,072)	$ 4,037,194	$ 4,012,187

Included in net assets without donor restrictions at September 30 are the following amounts that have not yet been recognized in net periodic pension cost:

	Pension Plans		Postretirement Plan	
	2019	2018	2019	2018
Unrecognized actuarial loss	$ (85,128,758)	$ (16,999,856)	$ (31,194,527)	$ (18,563,791)
Prior service credit	-	-	3,782,955	4,554,986
Total	$ (85,128,758)	$ (16,999,856)	$ (27,411,572)	$ (14,008,805)

Changes in plan assets and benefit obligations recognized in net assets without donor restrictions include:

	Pension Plans		Postretirement Plan	
	2019	2018	2019	2018
Actuarial loss (gain)	$ 68,254,545	$ (31,268,912)	$ 13,995,549	$ (59,977)
Amortization of actuarial loss	(125,643)	(1,606,497)	(1,364,813)	(1,494,178)
Amortization of prior service credit	-	-	772,031	772,031
Total	$ 68,128,902	$ (32,875,409)	$ 13,402,767	$ (782,124)

The weighted-average assumptions used in the measurement of the System's projected benefit obligation at September 30, 2019 and 2018 are as follows:

	Pension Plans		Postretirement Plan	
	2019	2018	2019	2018
Discount rate (all plans)	3.40 %	4.15 %	3.37 %	4.44 %
Expected rate of compensation increase (all plans)	N/A	N/A	N/A	N/A

The weighted-average assumptions used in the measurement of the System's net periodic pension cost for the years ended September 30, 2019 and 2018 are as follows:

	Pension Plans		Postretirement Plan	
	2019	2018	2019	2018
Discount rate:				
CHHI plans	4.15 %	3.90 %	4.44 %	4.16 %
SMMC plan	4.15	3.75	N/A	N/A
Expected long-term rate of return on plan assets:				
CHHI plans	7.00	7.00	N/A	N/A
SMMC plan	7.75	7.75	N/A	N/A
Expected rate of compensation increase:				
CHHI plans	N/A	N/A	N/A	N/A
SMMC plan	N/A	N/A	N/A	N/A

In selecting the expected long-term return on plan assets for the pension plans, the System considered the average rate of earnings on the funds invested or to be invested to provide for the benefits of these plans. This included considering the asset allocation and the expected returns likely to be earned over the life of the plans. Plan assets are invested in an actively managed portfolio that integrates asset allocation strategies across equity and debt markets within the United States. The portfolio objectives include long-term growth, balanced with moderate variability, with an expected shift to assets having a greater fixed income allocation as the plan population ages and nears retirement. The use of an appropriate asset management policy combines the various asset pools to ensure flexibility and to adapt to the changing retirement needs of the plan participants.

The pension plans' objectives are to have approximately 65 percent of plan assets invested in equities, approximately 30 percent invested in fixed income securities, and approximately 5 percent invested in cash and cash equivalents. The objective of the portfolio is to meet present and future benefit obligations through investments in the capital markets and to pay benefits in a timely manner.

The pension plans' weighted-average asset allocations at September 30, by asset category, are as follows:

	2019	2018
Asset category:		
Equity securities	73 %	73 %
Debt/fixed income securities	27	27
	100 %	100 %

The following table summarizes instruments measured at fair value on a recurring basis at September 30, 2019:

	Level 1	Level 2	NAV (1)	Total
Cash and cash equivalents	$ 7,675,745	$ -	$ -	$ 7,675,745
Mutual funds, fixed income	10,657,875	-	-	10,657,875
Marketable equity securities:				
Consumer discretionary	17,804,022	-	-	17,804,022
Consumer staples	14,541,995	-	-	14,541,995
Energy	5,923,832	-	-	5,923,832
Financials	24,511,200	-	-	24,511,200
Healthcare	21,450,658	-	-	21,450,658
Industrials	16,781,017	-	-	16,781,017
Information technology	26,193,825	-	-	26,193,825
Materials	2,002,186	-	-	2,002,186
Other	10,771,637	-	-	10,771,637
Real estate	1,987,336	-	-	1,987,336
Telecommunications	13,618,665	-	-	13,618,665
Utilities	3,400,601	-	-	3,400,601
Marketable debt securities	-	22,020,763	-	22,020,763
U.S. government and agency obligations	-	33,256,975	-	33,256,975
Pooled separate accounts:				
Money market accounts	-	-	1,130,928	1,130,928
Domestic equity accounts	-	-	66,472,388	66,472,388
Bond and mortgage accounts	-	-	55,535,528	55,535,528
Total	$ 177,320,594	$ 55,277,738	$ 123,138,844	$ 355,737,176

(1) Certain investments that are measured at fair value using the net asset value (NAV) per share (or its equivalent) practical expedient have not been categorized in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the consolidated balance sheets.

The following table summarizes instruments measured at fair value on a recurring basis at September 30, 2018:

	Level 1	Level 2	NAV (1)	Total
Cash and cash equivalents	$ 8,172,540	$ -	$ -	$ 8,172,540
Mutual funds, fixed income	12,068,462	-	-	12,068,462
Marketable equity securities:				
Consumer discretionary	14,008,437	-	-	14,008,437
Consumer staples	10,243,789	-	-	10,243,789
Exchange traded funds	21,867,830	-	-	21,867,830
Energy	8,086,666	-	-	8,086,666
Financials	22,309,789	-	-	22,309,789
Healthcare	21,060,497	-	-	21,060,497
Industrials	16,430,957	-	-	16,430,957
Information technology	25,005,074	-	-	25,005,074
Materials	3,713,937	-	-	3,713,937
Other	8,473,437	-	-	8,473,437
Real estate	359,453	-	-	359,453
Telecommunications	14,367,482	-	-	14,367,482
Utilities	3,688,174	-	-	3,688,174
Marketable debt securities	-	14,817,660	-	14,817,660
U.S. government and agency obligations	-	26,373,424	-	26,373,424
Pooled separate accounts:				
Money market accounts	-	-	1,094,184	1,094,184
Domestic equity accounts	-	-	65,047,877	65,047,877
Bond and mortgage accounts	-	-	59,949,683	59,949,683
Total	$ 189,856,524	$ 41,191,084	$ 126,091,744	$ 357,139,352

(1) Certain investments that are measured at fair value using the net asset value (NAV) per share (or its equivalent) practical expedient have not been categorized in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the consolidated balance sheets.

There were no Level 3 investments at September 30, 2019 and 2018. The following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at September 30, 2019 and 2018.

Cash and cash equivalents: The carrying amounts approximate fair value because of the short maturity of these financial instruments.

Marketable equity securities: Valued at the closing price reported on the active market on which the individual securities are traded.

Marketable debt securities: Valued based on spreads of published interest rate curves.

U.S. government and agency obligations: Valued based on spreads of published interest rate curves.

Pooled separate accounts: Valued using the net asset value (NAV) provided by the administrator of the related fund. The NAV is based on the value of the underlying assets owned by the fund minus applicable costs and liabilities and then divided by the number of shares outstanding.

The following represents the investment strategies of the pooled separate accounts:

Name of Fund	Fair Value at September 30, 2019	Fair Value at September 30, 2018	Investment Strategy	Unfunded Commitments	Redemption Frequency	Redemption Notice Period
Principal Core Plus Bond Separate Account	$ 55,535,526	$ 59,949,683	Invests primarily in intermediate-term, fixed-income investments such as public and private corporate bonds, commercial and residential mortgages, asset-backed securities, and US government and agency-backed securities. Value is added primarily through sector allocation and security selection. May enter into reverse repurchase agreements to attempt to enhance portfolio return and income.	N/A	Daily	1 day
Principal LargeCap S&P 500 Index Separate Account	56,177,741	54,033,079	Invests primarily in common stocks of companies that compose the S&P 500 Index. Attempts to mirror the investment performance of the Index by allocating assets in approximately the same weightings as the S&P 500 Index. Over the long-term, seeks a very close correlation to the performance of the S&P 500 Index.	N/A	Daily	1 day
Principal SmallCap Separate Account	10,294,647	11,014,796	Seeks long-term growth of capital and primarily invests in common stocks of small capitalization companies. Invests in companies with market capitalizations similar to those of companies in the Russell 2000 Index. Management of the fund looks at stocks with value and/or growth characteristics and constructs an investment portfolio that has a blend of stocks with these characteristics. May invest up to 25% of assets in foreign securities.	N/A	Daily	1 day
Principal Liquid Assets Separate Account	1,130,928	1,094,184	Seeks as high a level of current income as is considered consistent with preservation of principal and maintenance of liquidity. Invests in a portfolio of high quality, short-term money market instruments. Investments are U.S. dollar denominated securities which present minimal credit risks. Maintains a dollar weighted average portfolio maturity of 60 days or less.	N/A	Daily	1 day
Total	$ 123,138,844	$ 126,091,744				

The preceding methods described may produce a fair value calculation that may not be indicative of the net realizable value or reflective of future fair values. Furthermore, although the System believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

The System expects to contribute approximately $34,146,000 to the defined benefit plans and $1,850,000 to the postretirement plan in 2019.

The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid:

	Pension Plans	Postretirement Plan
Years ending September 30:		
2020	$ 20,960,000	$ 1,850,000
2021	22,222,000	1,778,000
2022	23,409,000	1,746,000
2023	24,835,000	1,850,000
2024	26,038,000	2,028,000
2025 - 2029	145,930,000	12,770,000

The weighted-average annual assumed rate of increase in the health care cost trend rate is 6.9 percent for non-Medicare and 5.55 percent for Medicare for the year beginning October 1, 2019, and is assumed to decrease to 4.5 percent for non-Medicare and Medicare for the year beginning October 1, 2025 and remain at that level thereafter. The health care cost trend rate assumption has a significant effect on the amounts reported for the postretirement benefit plan. A one-percentage-point change in the assumed health care cost trend rate would have the following effects:

	1% Increase	1% Decrease
Postretirement plan:		
Change in total of service and interest cost	$ 707,597	$ (557,914)
Change in postretirement benefit obligation	12,473,336	(9,888,340)

14. Professional and General Liability

The System uses a combination of self-insurance, purchased commercial professional liability and excess liability insurance to manage exposure to general and professional liability claims. The reserve recorded at September 30, 2019 and 2018, includes an amount for asserted, unasserted, and incurred but not reported professional and general liability claims.

As the System believes that the amount and timing of its future claims payments are reliably determinable, it discounts the amount accrued for losses resulting from professional liability claims using a weighted average of the trailing return on the lower risk investments in its investment portfolio and the risk-free interest rate corresponding to the timing of expected payments. The net present value of the projected payments was discounted using a weighted-average, risk-free rate of 2 percent in 2019 and 3 percent in 2018. This liability is adjusted for new claims information in the period such information becomes known. The estimated liability for the self-insured portion of professional and general liability claims was $22,625,000 at September 30, 2019 and $22,795,000 at September 30, 2018. The current portion of the liability for the self-insured portion of professional and general liability claims was $4,123,000 at September 30, 2019 and $5,631,000 at September 30, 2018, and is included in accrued expenses in the consolidated balance sheets. Insurance expense includes the losses resulting from professional liability claims and loss adjustment expense, as well as paid insurance premiums.

The System believes it has adequate self-insurance and insurance coverages and accruals for all asserted claims and it has no knowledge of unasserted claims which would exceed its self-insurance and insurance coverages and accruals.

15. Partnership Investments

HealthNet, Inc.

HealthNet, Inc. is a West Virginia nonprofit organization that provides aeromedical transportation services to patients. CHHI has a 33.33 percent ownership interest in HealthNet, Inc. This investment is accounted for under the equity method of accounting. Prior year losses have reduced CHHI's investment in HealthNet, Inc. to zero. CHHI has an affiliate payable of $2,171,000 at September 30, 2019 and $1,329,000 at September 30, 2018 included in accrued expenses in the consolidated balance sheets.

FMS Dialysis Cabell Huntington Dialysis Centers, LLC

In 2009, CHHI contributed cash of approximately $8,709,000 to FMS Dialysis Cabell Huntington Dialysis Centers, LLC (Dialysis Centers) in exchange for a 45 percent membership interest. Dialysis Centers then purchased CHHI's hemodialysis operations and related equipment in a purchase transaction totaling $16,923,000 In 2010, CHHI contributed cash of approximately $456,000 to the Dialysis Centers to fund the acquisition of a dialysis facility in Chesapeake, Ohio. Additionally, the partners of the Dialysis Centers contributed additional capital of approximately $2,100,000 to fund expansion activities; CHHI's contribution approximated $996,000. In 2018, Dialysis Centers entered into a new joint venture for the operation of a dialysis center located in West Hamlin, West Virginia. The capital contribution was paid out of cash retained in the joint venture.

Dialysis Centers provides hemodialysis services to dialysis patients residing primarily within the CHHI's service area. Equity earnings in Dialysis Centers approximated $563,000 in 2019 and $941,000 in 2018, and is included in equity income from partnership investments in the consolidated statements of operations. Cash distributions received from the Dialysis Centers approximated $269,000 in 2019 and $938,000 in 2018. CHHI's interest in the Dialysis Centers approximated $9,667,000 at September 30, 2019 and $9,373,000 at September 30, 2018.

Summary financial information of the Dialysis Centers for the years ended September 30 is as follows:

	2019	2018
Assets:		
Current assets	$ 5,319,399	$ 5,118,599
Property and equipment, net	2,861,688	3,379,619
Other assets	19,094,432	15,673,020
Total assets	$ 27,275,519	$ 24,171,238
Liabilities and stockholders' equity:		
Current liabilities	$ 2,402,866	$ 2,558,883
Long-term lease liability	2,706,277	-
Stockholders' equity	22,166,376	21,612,355
Total liabilities and stockholders' equity	$ 27,275,519	$ 24,171,238
Net patient service revenues	$ 14,050,275	$ 13,900,006
Net income	$ 1,327,115	$ 2,091,185

Ironton Medical Campus Partners, LLC and Ironton Medical Campus Partners II, LLC

In 2014, the Ironton-Lawrence County Area Community Action Organization, Inc. entered into a sale transaction of its Ironton Medical Building as a new market tax credit (NMTC) transaction. The NMTC transaction required the formation of Ironton Medical Campus Partners, LLC, which holds the assets and assumed liabilities for the medical facility. Certain nonmedical assets and assumed liabilities were sold to Ironton Medical Campus Partners II, LLC as part of the transaction.

SMMC purchased a 65 percent interest in Ironton Medical Campus Partners, LLC and Ironton Medical Campus Partners II, LLC (Ironton). SMMC is the nonmanaging member and contributed $938,848. Ironton has been organized to acquire a fee simple interest in property to own, maintain, lease and sell or otherwise dispose of property. SMMC's majority interest does not give them the ability to exercise control and therefore the investment in Ironton is accounted for under the equity method of accounting. SMMC's interest in Ironton approximated $2,810,000 at September 30, 2019 and $2,384,000 at September 30, 2018.

Summary financial information of Ironton for the years ended September 30 is as follows:

	2019	2018
Assets:		
Current assets	$ 1,910,995	$ 1,500,633
Property and equipment, net	13,269,106	13,618,890
Total assets	$ 15,180,101	$ 15,119,523
Liabilities and stockholders' equity:		
Current liabilities	$ 874,343	$ 979,510
Long-term debt	9,982,151	10,472,617
Stockholders' equity	4,323,607	3,667,396
Total liabilities and stockholders' equity	$ 15,180,101	$ 15,119,523
Total revenues	$ 2,359,489	$ 1,701,900
Net income	$ 553,513	$ 305,984

16. Operating Leases

The System leases certain equipment, buildings and land under the terms of noncancellable leases expiring on various dates through 2039. These leases generally contain renewal options for periods ranging from one to five years and require the System to pay all executory costs (property taxes, maintenance and insurance).

The schedule of future minimum lease payments under these operating leases, as of September 30, 2019, is approximately as follows:

Years ending September 30:	
2020	$ 4,539,000
2021	3,392,000
2022	2,338,000
2023	1,518,000
2024	1,188,000
Thereafter	21,290,000
Total future minimum lease payments	$ 34,265,000

Rent expense under these leases was approximately $6,915,000 in 2019 and $7,742,000 in 2018.

17. Related Party Transactions

CHHI participates in various medical education programs and research activities in cooperation with the Marshall University Joan C. Edwards School of Medicine (the School of Medicine). CHHI recorded expenses of approximately $25,580,000 in 2019 and $23,890,000 in 2018, related to these activities, which are included in professional fees in the consolidated statements of operations.

On July 1, 2012, CHHI entered into an Academic Medical Center Agreement (the Agreement) with the School of Medicine and University Physicians & Surgeons, Inc. (UP&S). The Agreement memorialized the past supplemental support provided to the School of Medicine, defines the Academic Medical Center as being comprised of CHHI, the School of Medicine and UP&S and defines a process for determining support in the future.

In 1998, the Marshall University Medical Center opened on the CHHI's campus. During 2013, CHHI opened provider based clinics on its campus for which UP&S provides physician services.

CHHI had amounts due to the School of Medicine, related to the provider based clinics, of approximately $788,000 at September 30, 2019 and $385,000 at September 30, 2018 included in accrued expenses in the consolidated balance sheets.

SMMC entered into an operating lease with Ironton for the lease of the St. Mary's Medical Campus in Ironton, Ohio, a free standing emergency department. This lease was assumed in the acquisition of SMMC (Note 3). The lease is for a term of twenty-five years with an option to purchase after the first seven years at an amount equal to SMMC's proportionate share of the remaining debt service applicable to the funding and creation of the facility. The base rent is $588,323 with a 10 percent escalation every five years. In addition to the base rent, SMMC is charged additional rent based upon its proportionate share of estimated operating expenses. Rent paid to Ironton was approximately $1,063,000 in 2019 and $458,000 in 2018.

18. Liquidity and Availability

Financial assets available for general expenditure within one year of the balance sheet date consist of the following at September 30:

	2019	2018
Cash and cash equivalents	$ 202,032,591	$ 142,785,484
Patient accounts receivable	142,133,689	134,546,574
Total	$ 343,629,302	$ 277,332,058

Funds held by trustee and funds held by Foundations are not available for general expenditure within the next year and are not reflected in the amounts above. However, the System does have certain Board designated investments that could be made available for general expenditure within the next year, if necessary. Additionally, the System maintains revolving lines of credit as discussed in Note 10.

As part of the System's liquidity management, it has a policy to structure its financial assets to be available as its general expenditures, liabilities and other obligations come due.

19. Functional Expenses

The System provides general health care and related services to individuals within its geographic region. Expenses related to providing these services in 2019 are as follows:

	Healthcare Services	General and Administrative	Fundraising	Total
Salaries and wages	$ 304,602,989	$ 57,711,626	$ 137,607	$ 362,452,222
Employee benefits	119,593,705	19,403,233	-	138,996,938
Supplies	240,222,865	4,529,220	-	244,752,085
Professional fees	102,938,864	3,651,006	-	106,589,870
Purchased services	56,695,938	24,779,521	256,469	81,731,928
Plant operations	43,940,436	19,261,219	-	63,201,655
Interest	11,591,331	1,652,407	-	13,243,738
Depreciation and amortization	27,986,141	6,903,155	-	34,889,296
Provider tax	26,586,471	-	-	26,586,471
Insurance	6,206,800	2,426,108	-	8,632,908
Other	6,076,490	14,266,166	1,284,715	21,627,371
Total	$ 946,442,030	$ 154,583,661	$ 1,678,791	$ 1,102,704,482

In 2018, the System incurred approximately $655,668,000 of expenses related to healthcare services, approximately $120,914,000 of expenses related to general and administrative costs, and approximately $1,881,000 of expenses related to fundraising.

The consolidated financial statements report certain expense categories that are attributable to more than one health care service or support function. Therefore, these expenses require an allocation on a reasonable basis that is consistently applied. Costs not directly attributable to a function, including depreciation and amortization and other occupancy costs, are allocated to a function based on a square footage basis.

20. Concentration of Credit Risk

The System grants credit without collateral to its patients, most of who are local residents and are insured under third-party payor agreements, primarily with Medicare, Medicaid, and various commercial insurance companies. The System maintains allowances for potential credit losses and such losses have historically been within management's expectations.

The mix of receivables from patients and third-party payors is as follows at September 30, 2019:

	2019	2018
Medicare	22 %	24 %
Medicaid	14	14
Blue Cross	15	16
Commercial/HMO/Other	32	27
Patients	17	19
Total	100 %	100 %

Approximately 17 percent of the System's employees are covered by a collective bargaining agreement with District 1199, The Health Care and Social Service Union, SEIU, CTW. This agreement expires on November 2, 2021.

Cabell Huntington Hospital, Inc. and Subsidiaries

Consolidating Schedule, Balance Sheet
September 30, 2019

	Cabell Huntington Hospital	St. Mary's Medical Center	Eliminations	Total Obligated Group	Cabell Huntington Hospital Foundation	CHH-Cabell Development Corporation	Cabell Huntington Hospital Auxiliary	St. Mary's Medical Center Foundation	St. Mary's Medical Management and Subsidiaries	All Other (Combined)	Eliminations	Total Consolidated
Assets												
Current Assets												
Cash and cash equivalents	$ 186,690,873	$ 10,482,987	$ -	$ 197,173,860	$ 2,116,895	$ 146,901	$ 602,995	$ 143,092	$ 668,732	$ 1,180,112	$ -	$ 202,032,591
Patient accounts receivable, net	74,291,628	62,969,785	-	137,261,713	-	-	-	-	4,871,976	-	-	142,133,689
Inventories of supplies	9,304,301	10,994,814	-	20,299,115	-	-	281,491	5,976	721,840	-	-	21,308,422
Estimated third-party payor settlements	16,384,420	1,538,685	-	17,923,105	-	-	-	-	-	-	-	17,923,105
Prepaid expenses and other current assets	23,796,828	5,943,596	(5,925,449)	23,813,977	963,572	(21,908)	75,847	79,218	17,512,737	200,181	(19,066,049)	23,255,675
Total current assets	310,467,350	91,929,869	(5,925,449)	396,471,770	2,780,467	125,093	960,337	228,286	23,775,285	1,380,293	(19,066,049)	406,653,482
Investments												
Board designated	188,467,699	92,890,578	-	281,358,211	-	-	-	-	332,311	-	-	281,690,522
Funds held by trustee	25,984,789	-	-	25,984,789	-	-	-	-	-	-	-	25,984,789
Funds held by Foundations	-	-	-	-	226,867	-	-	1,717,638	-	-	-	1,944,505
Total investments	214,452,424	92,890,578	-	307,343,000	226,867	-	-	1,717,638	332,311	-	-	309,619,816
Property and Equipment, Net	253,745,838	192,859,760	-	446,605,599	-	648,687	5,049	-	484,104	1,693,317	-	449,446,755
Partnership Investments	184,553,629	3,837,064	(174,208,105)	14,182,588	-	-	-	-	160,170	172,706	(221,527)	14,293,937
Other Assets, Net	15,014,538	5,891,665	-	15,906,203	824,394	-	-	-	-	-	-	15,930,817
Total assets	$ 976,233,779	$ 387,418,954	$ (180,133,554)	$ 1,183,519,179	$ 3,931,528	$ 773,780	$ 965,386	$ 1,945,924	$ 24,751,870	$ 3,246,316	$ (19,289,576)	$ 1,199,944,407

Cabell Huntington Hospital, Inc. and Subsidiaries

Consolidating Schedule, Balance Sheet
September 30, 2019

	Cabell Huntington Hospital	St. Mary's Medical Center	Eliminations	Total Obligated Group	Cabell Huntington Hospital Foundation	CHH-Cabell Development Corporation	Cabell Huntington Hospital Auxiliary	St. Mary's Medical Center Foundation	St. Mary's Medical Management and Subsidiaries	All Other (Combined)	Eliminations	Total Consolidated
Liabilities and Net Assets												
Current Liabilities												
Lines of credit	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 70,000	$ 357,196	$ -	$ 427,196
Current maturities of long-term debt	7,162,608	17,824	-	7,179,832	-	-	-	-	396,858	558,086	-	8,134,776
Accounts payable	17,140,175	25,468,595	(5,925,449)	36,683,321	-	4,448	94,224	1,198	18,878,390	170,934	(17,162,579)	38,669,936
Accrued expenses	77,815,213	24,985,289	-	102,800,502	-	56,418	7,841	-	3,193,391	2,090,487	(2,126,997)	106,821,642
Estimated third-party payor settlements	1,977,859	-	-	1,977,859	-	-	-	-	-	-	-	1,977,859
Total current liabilities	103,895,855	50,471,708	(5,925,449)	148,441,514	-	60,866	42,065	1,198	22,538,639	3,176,703	(19,289,576)	154,971,509
Long-Term Debt, Net	352,571,568	87,795,242	(87,747,633)	352,619,177	-	-	-	-	276,818	-	-	352,895,995
Derivative Financial Instruments	12,671,446	-	-	12,671,446	-	-	-	-	-	-	-	12,671,446
Other Liabilities	42,360	2,243,016	-	2,285,376	-	-	-	-	-	-	-	2,285,376
Accrued Professional Liability	9,934,269	8,441,000	-	18,375,269	-	-	-	-	250,000	-	-	18,625,269
Accrued Pension and Postretirement Liabilities	165,119,218	141,389,487	-	306,507,703	-	-	-	-	-	-	-	306,507,703
Total liabilities	644,233,214	270,340,453	(73,673,082)	840,900,585	-	60,866	42,065	1,198	23,065,455	3,176,703	(19,289,576)	847,957,296
Net Assets												
Controlling interest	332,000,565	117,020,109	(106,460,472)	342,560,202	671,073	362,280	923,321	44,553	1,762,563	371,752	-	348,695,744
Noncontrolling interest	-	-	-	-	-	350,634	-	-	(78,148)	(302,139)	-	(27,953)
Total net assets without donor restrictions	332,000,565	117,020,109	(106,460,472)	342,560,202	671,073	712,914	923,321	44,553	1,684,415	69,613	-	348,667,791
Net assets with donor restrictions	-	58,392	-	58,392	3,260,455	-	-	1,900,173	-	-	-	5,219,020
Total net assets	332,000,565	117,078,501	(106,460,472)	342,618,594	3,931,528	712,914	923,321	1,944,726	1,684,415	69,613	-	353,887,111
Total liabilities and net assets	$ 976,233,779	$ 387,418,954	$ (180,133,554)	$ 1,183,519,179	$ 3,931,528	$ 773,780	$ 965,386	$ 1,945,924	$ 24,751,870	$ 3,246,316	$ (19,289,576)	$ 1,199,844,407

Cabell Huntington Hospital, Inc. and Subsidiaries

Consolidating Schedule, Statement of Operations
Year Ended September 30, 2019

	Cabell Huntington Hospital	St. Mary's Medical Center	Eliminations	Total Obligated Group	Cabell Huntington Hospital Foundation	CHH-Cabell Development Corporation	Cabell Huntington Hospital Auxiliary	St. Mary's Medical Center Foundation	St. Mary's Medical Management and Subsidiaries	All Other (Combined)	Eliminations	Total Consolidated
Revenues												
Net patient service revenues	$ 566,055,641	$ 423,077,480	$ -	$ 1,011,133,121	$ -	$ -	$ -	$ -	$ 35,777,897	$ 2,087,969	$ -	$ 1,048,978,987
Other revenues, including net assets released from restrictions for operations	56,288,097	13,049,348	-	69,337,445	1,206,136	259,787	1,689,658	496,726	3,659,584	3,655,280	(7,211,274)	73,093,322
Total revenues	644,343,738	436,126,828	-	1,080,470,566	1,206,136	259,787	1,689,658	496,726	39,437,481	5,723,249	(7,211,274)	1,122,072,309
Expenses												
Salaries and wages	182,577,105	146,932,100	-	329,509,205	488,958	-	-	-	30,424,884	2,629,975	-	362,452,222
Employee benefits	68,411,124	55,354,719	-	123,765,843	-	-	-	-	4,823,109	407,986	-	129,996,938
Supplies	138,895,326	102,547,165	-	241,442,491	-	-	15,798	-	3,028,798	264,070	-	244,752,085
Professional fees	85,562,481	22,571,939	-	108,254,420	-	2,167	-	-	4,247,265	196,152	(4,110,164)	108,589,970
Purchased services	46,087,714	27,563,078	-	75,650,793	-	-	-	258,489	6,100,112	1,000,434	(1,275,899)	81,731,928
Plant operations	38,302,045	21,863,452	-	60,165,497	-	-	-	-	2,758,982	277,176	-	63,201,655
Interest	10,429,314	2,730,851	-	13,151,165	-	-	-	-	36,837	55,736	-	13,243,738
Depreciation and amortization	21,872,387	12,480,269	-	34,352,656	-	53,034	1,057	-	267,375	215,174	-	34,889,296
Provider tax	15,289,582	11,213,808	-	26,503,390	-	-	-	-	83,081	-	-	26,586,471
Insurance	2,940,912	4,696,342	-	7,638,254	-	-	-	-	786,300	211,354	-	8,632,908
Other	13,075,144	5,522,282	-	18,597,426	707,804	2,623	1,680,095	550,493	1,346,823	557,237	(1,825,230)	21,627,371
Total expenses	623,554,134	422,875,006	-	1,046,429,140	1,196,762	57,824	1,696,928	818,982	53,903,424	5,815,324	(7,211,274)	1,102,704,482
Operating income (loss)	20,789,604	13,251,822	-	34,041,426	9,374	201,963	(37,262)	(320,256)	(14,465,963)	(92,075)	-	19,367,827
Other Income (Loss)												
Investment income	9,487,542	3,371,689	-	12,859,031	3,450	-	-	-	18,705	-	-	12,881,186
Change in fair value of derivative financial instruments	(5,136,326)	-	-	(5,136,326)	-	-	-	-	-	-	-	(5,136,326)
Equity income from partnership investments	892,960	445,421	-	1,338,381	-	-	-	-	-	(92,294)	(37,220)	1,008,867
Acquisition costs	(531,071)	-	-	(531,071)	-	-	-	-	-	-	-	(531,071)
Total other income (loss)	4,713,105	3,815,910	-	8,330,015	3,450	-	-	-	18,705	(92,294)	(37,220)	8,222,656
Revenues in excess of (less than) expenses	25,502,709	17,068,732	-	42,371,441	13,424	201,963	(37,262)	(320,256)	(14,447,258)	(184,369)	(37,220)	27,590,483
Pension and Postretirement Liabilities Adjustment	(53,937,835)	(27,593,774)	-	(81,531,609)	-	-	-	-	-	-	-	(81,531,609)
Net Assets Released From Restrictions for Property and Equipment	2,866,649	-	-	2,866,649	-	-	-	-	-	-	-	2,866,649
Equity Distributions	-	-	-	-	-	(253,110)	-	-	(171,075)	10,000	-	(414,185)
Transfers From (To) Affiliates	-	(12,616,139)	-	(12,616,139)	-	-	-	282,298	12,333,931	-	-	-
Increase (decrease) in net assets without donor restrictions	$ (25,568,537)	$ (23,141,181)	$ -	$ (49,109,718)	$ 13,424	$ (51,147)	$ (37,262)	$ (38,028)	$ (2,284,402)	$ (174,369)	$ (37,220)	$ (51,718,722)

Cabell Huntington Hospital, Inc. and Subsidiaries

Consolidating Schedule, Statement of Changes in Net Assets

Year Ended September 30, 2019

	Cabell Huntington Hospital	St. Mary's Medical Center	Eliminations	Total Obligated Group	Cabell Huntington Hospital Foundation	CHH-Cabell Development Corporation	Cabell Huntington Hospital Auxiliary	St. Mary's Medical Center Foundation	St. Mary's Medical Management and Subsidiaries	All Other (Combined)	Eliminations	Total Consolidated
Net Assets Without Donor Restrictions												
Revenues in excess of (less than) expenses	$ 25,302,709	$ 17,068,732	$ -	$ 42,371,441	$ 13,424	$ 201,963	$ (37,262)	$ (320,236)	$ (14,447,256)	$ (184,369)	$ (37,220)	$ 27,560,483
Pension and postretirement liabilities adjustment	(53,937,895)	(27,593,774)	-	(81,531,669)	-	-	-	-	-	-	-	(81,531,669)
Net assets released from restrictions for property and equipment	2,666,649	-	-	2,666,649	-	-	-	-	-	-	-	2,666,649
Equity distributions	-	-	-	-	-	(253,110)	-	-	(171,075)	10,000	-	(414,185)
Transfers from (to) affiliates	-	(12,618,139)	-	(12,618,139)	-	-	-	262,208	12,533,931	-	-	-
Increase (decrease) in net assets without donor restrictions	(25,968,537)	(23,141,181)	-	(49,109,718)	13,424	(51,147)	(37,262)	(58,028)	(2,284,402)	(174,369)	(37,220)	(51,718,722)
Net Assets With Donor Restrictions												
Contributions and investment income, net	-	15,282	-	15,282	2,984,220	-	-	217,956	-	-	-	3,187,458
Transfers from (to) affiliates	2,666,649	-	-	2,666,649	(2,666,649)	-	-	-	-	-	-	-
Net assets released from restrictions	(2,666,649)	-	-	(2,666,649)	(555,303)	-	-	(221,461)	-	-	-	(3,443,413)
Increase (decrease) in net assets with donor restrictions	-	15,282	-	15,282	(237,732)	-	-	(3,505)	-	-	-	(245,975)
Change in net assets	(25,968,537)	(23,125,919)	-	(49,094,436)	(244,308)	(51,147)	(37,262)	(61,533)	(2,284,402)	(174,369)	(37,220)	(51,964,697)
Net Assets, Beginning	357,969,102	140,204,420	(106,460,472)	391,713,050	4,175,836	764,061	960,583	1,986,259	3,970,817	243,982	37,220	403,851,808
Net Assets, Ending	$ 332,000,565	$ 117,078,501	$ (106,460,472)	$ 342,618,584	$ 3,931,528	$ 712,914	$ 923,321	$ 1,944,726	$ 1,686,415	$ 69,613	$ -	$ 351,887,111

Cabell Huntington Hospital, Inc. and Subsidiaries

Combining Schedule - All Other, Balance Sheet
September 30, 2019

	Mountain Regional Services	Tri-State MRI	Mountain Health Network and Subsidiary	Occumed	Vanguard Financial Services	Eliminations	Total Combined
Assets							
Current Assets							
Cash and cash equivalents	$ 8,362	$ 536,978	$ 277,467	$ 78,386	$ 278,919	$ -	$ 1,180,112
Patient accounts receivable, net	-	-	-	-	-	-	-
Inventories of supplies	-	-	-	-	-	-	-
Estimated third-party payor settlements	-	-	-	-	-	-	-
Prepaid expenses and other current assets	490	-	110,021	1,494	88,176	-	200,181
Total current assets	8,852	536,978	387,488	79,880	367,095	-	1,380,293
Investments							
Board designated	-	-	-	-	-	-	-
Funds held by trustee	-	-	-	-	-	-	-
Funds held by Foundations	-	-	-	-	-	-	-
Total investments	-	-	-	-	-	-	-
Property and Equipment, Net	434,856	-	13,000	1,240,304	5,157	-	1,693,317
Partnership Investments	-	-	172,706	-	-	-	172,706
Other Assets, Net	-	-	-	-	-	-	-
Total assets	$ 443,708	$ 536,978	$ 573,194	$ 1,320,184	$ 372,252	$ -	$ 3,246,316

Cabell Huntington Hospital, Inc. and Subsidiaries

Combining Schedule - All Other, Balance Sheet
September 30, 2019

	Mountain Regional Services	Tri-State MRI	Mountain Health Network and Subsidiary	Occumed	Vanguard Financial Services	Eliminations	Total Combined
Liabilities and Net Assets							
Current Liabilities							
Lines of credit	$ -	$ -	$ -	$ 357,196	$ -	$ -	$ 357,196
Current maturities of long-term debt	-	-	-	558,086	-	-	558,086
Accounts payable	-	-	637,008	-	(466,074)	-	170,934
Accrued expenses	215,511	536,978	41,742	1,386,905	(90,649)	-	2,090,487
Estimated third-party payor settlements	-	-	-	-	-	-	-
Total current liabilities	215,511	536,978	678,750	2,302,187	(556,723)	-	3,176,703
Long-Term Debt, Net	-	-	-	-	-	-	-
Derivative Financial Instruments	-	-	-	-	-	-	-
Other Liabilities	-	-	-	-	-	-	-
Accrued Professional Liability	-	-	-	-	-	-	-
Accrued Pension and Postretirement Liabilities	-	-	-	-	-	-	-
Total liabilities	215,511	536,978	678,750	2,302,187	(556,723)	-	3,176,703
Net Assets							
Controlling interest	228,197	-	(105,556)	(679,864)	928,975	-	371,752
Noncontrolling interest	-	-	-	(302,139)	-	-	(302,139)
Total net assets without donor restrictions	228,197	-	(105,556)	(982,003)	928,975	-	69,613
Net assets with donor restrictions	-	-	-	-	-	-	-
Total net assets	228,197	-	(105,556)	(982,003)	928,975	-	69,613
Total liabilities and net assets	$ 443,708	$ 536,978	$ 573,194	$ 1,320,184	$ 372,252	$ -	$ 3,246,316

Cabell Huntington Hospital, Inc. and Subsidiaries
Combining Schedule - All Other, Statement of Operations
Year Ended September 30, 2019

	Mountain Regional Services	Tri-State MRI	Mountain Health Network and Subsidiary	Occumed	Vanguard Financial Services	Eliminations	Total Combined
Revenues							
Net patient service revenues	$ -	$ -	$ -	$ 2,067,969	$ -	$ -	$ 2,067,969
Other revenues, including net assets released from restrictions for operations	-	537,136	1,825,230	-	1,292,914	-	3,655,280
Total revenues	-	537,136	1,825,230	2,067,969	1,292,914	-	5,723,249
Expenses							
Salaries and wages	-	806	750,275	1,352,359	526,535	-	2,629,975
Employee benefits	-	176	37,882	220,152	149,776	-	407,986
Supplies	-	948	3,623	115,144	144,355	-	264,070
Professional fees	-	-	-	170,588	25,594	-	196,182
Purchased services	1,855	34,602	937,767	25,704	506	-	1,000,434
Plant operations	-	20,343	-	75,029	181,804	-	277,176
Interest	-	-	-	55,736	-	-	55,736
Depreciation and amortization	-	136,159	-	65,399	13,616	-	215,174
Provider tax	-	-	-	-	-	-	-
Insurance	-	206,551	-	4,803	-	-	211,354
Other	5,706	100,331	118,945	45,623	286,632	-	557,237
Total expenses	7,561	499,916	1,848,492	2,130,537	1,328,818	-	5,815,324
Operating income (loss)	(7,561)	37,220	(23,262)	(62,568)	(35,904)	-	(92,075)
Other Income (Loss)							
Investment income	-	-	-	-	-	-	-
Change in fair value of derivative financial instruments	-	-	-	-	-	-	-
Equity income from partnership investments	-	-	(92,294)	-	-	-	(92,294)
Acquisition costs	-	-	-	-	-	-	-
Total other income (loss)	-	-	(92,294)	-	-	-	(92,294)
Revenues in excess of (less than) expenses	(7,561)	37,220	(115,556)	(62,568)	(35,904)	-	(184,369)
Pension and Postretirement Liabilities Adjustment	-	-	-	-	-	-	-
Net Assets Released From Restrictions for Property and Equipment	-	-	-	-	-	-	-
Equity Distributions	-	-	10,000	-	-	-	10,000
Transfers From (To) Affiliates	-	-	-	-	-	-	-
Increase (decrease) in net assets without donor restrictions	$ (7,561)	$ 37,220	$ (105,556)	$ (62,568)	$ (35,904)	$ -	$ (174,369)

Cabell Huntington Hospital, Inc. and Subsidiaries

Combining Statement of Changes in Net Assets
Year Ended September 30, 2019

	Mountain Regional Services	Tri-State MRI	Mountain Health Network and Subsidiary	Occumed	Vanguard Financial Services	Eliminations	Total Combined
Net Assets Without Donor Restrictions							
Revenues in excess of (less than) expenses	$ (7,561)	$ 37,220	$ (115,556)	$ (62,568)	$ (35,904)	$ -	$ (184,369)
Pension and postretirement liabilities adjustment	-	-	-	-	-	-	-
Net assets released from restrictions for property and equipment	-	-	-	-	-	-	-
Equity distributions	-	-	10,000	-	-	-	10,000
Transfers from (to) affiliates	-	-	-	-	-	-	-
Increase (decrease) in net assets without donor restrictions	(7,561)	37,220	(105,556)	(62,568)	(35,904)	-	(174,369)
Net Assets With Donor Restrictions							
Contributions and investment income, net	-	-	-	-	-	-	-
Transfers from (to) affiliates	-	-	-	-	-	-	-
Net assets released from restrictions	-	-	-	-	-	-	-
Increase (decrease) in net assets with donor restrictions	-	-	-	-	-	-	-
Change in net assets	(7,561)	37,220	(105,556)	(62,568)	(35,904)	-	(174,369)
Net Assets, Beginning	235,758	(37,220)	-	(919,435)	964,879	-	243,982
Net Assets, Ending	$ 228,197	$ -	$ (105,556)	$ (982,003)	$ 928,975	$ -	$ 69,613

Financial Projections

HIMG - ST. MARY'S

Financial Projections (FY21-FY23)

	FY21	FY22	FY23	Assumptions
Professional Revenue	$ 84,632,116	$ 85,690,017	$ 86,761,143	1.25% increase
Ancillary Revenue	80,986,517	82,606,247	84,258,372	2% increase
Total Gross Revenue	***165,618,633***	***168,296,265***	***171,019,515***	
Est. Professional Allowance	(44,234,984)	(44,787,921)	(45,347,770)	1.25% increase
Est. Ancillary/Pharmacy Allowance	(45,768,088)	(46,683,450)	(47,617,119)	2% increase
Total Allowance	***(90,003,072)***	***(91,471,371)***	***(92,964,889)***	
Total Net Patient Income	75,615,561	76,824,894	78,054,626	
Other Operating Income	1,057,418	1,057,418	1,057,418	Changed to Flat - mostly rent
Total Net Operating Income	***76,672,979***	***77,882,312***	***79,112,044***	
Physician Compensation	20,322,914	20,322,914	20,322,914	
Midlevel Compensation	3,209,248	3,273,433	3,338,902	2% increase
Employee Compensation	15,998,467	16,318,436	16,644,805	2% increase
Total Salary, Wages and Benefits	***39,530,629***	***39,914,783***	***40,306,621***	
Billing Costs (est. 6% Phys Prof Rev)				
Supplies	23,134,261	23,828,289	24,543,137	3% increase
ProFees	1,349,699	1,376,693	1,404,227	2% increase
Information Technology	768,261	775,944	783,703	1% increase
Rent	3,603,176	3,603,176	3,603,176	
Equipment	1,623,320	1,655,786	1,688,902	2% increase
Malpractice Insurance	983,245	1,002,910	1,022,968	2% increase
Depreciation	903,847	903,847	903,847	Changed to Flat
Other Expenses	2,098,847	2,109,341	2,119,888	0.5% increase
Total Expenses	***73,995,285***	***75,170,769***	***76,376,469***	
Net Income	***$ 2,677,694***	***$ 2,711,542***	***$ 2,735,575***	

Utilization Assumptions

Section N Assumptions

- FY20 projected volumes are adjusted for COVID-19 impact using 5 months' data multiplied by 90% (5months) and added it to April YTD (7 months)
- FY21 projected volumes are anticipated to be back to FY19 actual volumes
- FY22 and FY 23 projected volumes are based on the following assumptions:
    - Acute care patient days to increase 1.0% and discharges 1.25%
    - Skilled Nursing patient days to increase 1.0% and discharges 1.0%
    - Psychiatric Unit patient days to increase 1.0% and discharges 1.0%
    - OR Minutes (General) 2.0 %
    - OR Patients (General) 1.5 %
    - Delivery/Births -1.0 %
    - Outpatient Clinic Patient Visits 3.0 %
    - ER Patient Visits -1.0 %
    - Radiology Procedures 1.0 %
    - CT Scans 2.5 %
    - MRI Scans 1.0 %
    - Lithotripsy (Procedures) 1.0 %
    - Observation Visits 4.0 %
    - Observation Hours 2.0 %
    - Respiratory Therapy (Procedures) 1.0 %
    - Physical Therapy (Procedures) 4.0 %
    - Electrocardiology (Procedures) 2.5 %
    - Laboratory (Procedures) 2.0 %

SECTION O: SPECIAL NEEDS AND CIRCUMSTANCES OF FACILITIES PROVIDING A SUBSTANTIAL PORTION OF SERVICES TO OUT-OF-STATE POPULATIONS

If the proposed service will provide a substantial portion of its services or resources to individuals not residing in the project's service area or in West Virginia, document that fact with pertinent information and data.

For St. Mary's, almost 15% of St. Mary's inpatients are residents of Lawrence County, Ohio. HIMG has a similar patient mix.

SECTION P: COMMUNITY SUPPORT

If you wish, you may attach letters of support and endorsement from:

- **the service population at large**
- **members of the medical community and provider organizations/institutions/services**
- **consumer/civic organizations**
- **community service providers**

Letters of support may be submitted under separate cover.

St. Mary's Medical Center, Inc.
CON File #20-2-11852-P

The following affidavit must be completed by the **Chief Executive Officer** identified in response of Question 1 of Section A, Page 1.

COUNTY OF CABELL

STATE OF WEST VIRGINIA, to wit:

Upon first being duly sworn, I hereby state that, to the best of my information, knowledge, and belief, the information provided in this application is true and correct. I further state that the applicant is in full compliance with the financial disclosure provisions of W.Va. Code § 16-29B-18, W.Va. Code § 16-5F-1 *et seq.* or W. Va. C.S.R. § 65-15-1 *et seq.*

Todd A. Campbell
(Print Name)

(Signature)

President & CEO
(Title)

Sworn to, stated, and subscribed before me on this 6th **day of** May, **20** 20.

Tammy J. Meadows
Notary Public

OFFICIAL SEAL
NOTARY PUBLIC
STATE OF WEST VIRGINIA
TAMMY J. MEADOWS
2900 FIRST AVENUE
HUNTINGTON, WV 25702
My Commission Expires OCTOBER 22, 2022

(Notary Stamp)

St. Mary's Medical Center, Inc.
CON File #20-2-11852-P

The following affidavit must be completed by the **person who prepared the application** identified in response of Question 3 of Section A, Page 2.

COUNTY OF KANAWHA

STATE OF WEST VIRGINIA, to wit:

Upon first being duly sworn, I hereby state that, to the best of my information, knowledge, and belief, the information provided in this application is true and correct. I further state that the applicant is in full compliance with the financial disclosure provisions of W.Va. Code § 16-29B-18, W.Va. Code § 16-5F-1 *et seq.* or W. Va. C.S.R. § 65-15-1 *et seq.*

Raymona A. Kinneberg
(Print Name)

Raymona A. Kinneberg
(Signature)

President, RKSB Health Care Consultants, Inc.
(Title)

Sworn to, stated, and subscribed before me on this 19th **day of** May, 2020.

OFFICIAL SEAL
NOTARY PUBLIC
STATE OF WEST VIRGINIA
WHITNEY E. HESS
210 MacCORKLE AVE SE
CHARLESTON, WV 25314
My Commission Expires July 25, 2023

Whitney E. Hess
Notary Public

(Notary Stamp)