ADDENDUM A

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Palomar Pomerado Health

FINANCE COMMITTEE MEETING

(BOARD MEETING WITH RESPECT TO BOARD MEMBERS ON THE COMMITTEE)

Conference Rooms B&C, Administrative Offices, 15255 Innovation Drive, San Diego, CA

Tuesday, January 23, 2007, Meeting Minutes

AGENDA ITEM	DISCUSSION	CONCLUSION/ACTION	FOLLOW UP
NOTICE OF MEETING	The notice of meeting was mailed before close of business on Friday, January 19, 2007, which is consistent with legal requirements		
MEETING CALLED TO ORDER	6:00 p.m. by Chairman Ted Kleiter		
ESTABLISHMENT OF QUORUM	Present: Directors Nancy Bassett, R.N., Linda Greer, R.N., Marcelo Rivera, M.D., and Ted Kleiter; and Finance Committee Member Michael Covert Absent: Finance Committee Members Robert Trifunovic, M.D., and Benjamin Kanter, M.D.		
ATTENDANCE	Also in attendance were Bob Hemker and Secretary Tanya Howell		
PUBLIC COMMENTS	There were no public comments.		
INFORMATION ITEM(S)	• Ted Kleiter acknowledged Bob Hemker's representation of PPH as a member of the ACHD Finance Committee and a member of the ALPHA Council, and congratulated him on his recent appointment as the incoming Chair of the HFMA CFO Forum's Peer Leader Council • Bob Hemker distributed an updated Program Review Calendar *(copy attached)* o Periodic presentations scheduled to be brought before the Finance Committee, with a strategic focus • Bob Hemker also distributed a copy of a Moody's Investors Service Publication, "Not-for-Profit Healthcare Sector: 2007 Industry Outlook" *(copy attached)* • Ted Kleiter acknowledged the post closing dinner celebrating the closing of the 2006 issue of Revenue Bonds	***INFORMATION ONLY***	A copy of the Program Review Calendar is to be sent to the full Board, with an invitation to attend as guests at future Finance Committee meetings to hear the Program Reviews first-hand.
MINUTES DECEMBER 5, 2006	No discussion.	**MOTION:** By Director Bassett, seconded by Director Greer and carried to approve the minutes from the December 5, 2006, Finance Committee meeting as presented	
ANNUAL REVIEW OF FINANCE COMMITTEE BYLAWS	No changes were proposed to the existing Bylaws as they relate to the Finance Committee.	**MOTION:** By Director Bassett, seconded by Michael Covert and carried to approve Bylaws of Palomar Pomerado Health as they relate to the Board Finance Committee	Forwarded to the February 12, 2007, Board of Directors meeting as information

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Agenda Item	Discussion	Conclusion/Action	Follow Up
Update on Information Systems Strategic Plan – 2002	Utilizing the attached presentation, Steve Tanaka, CIO, brought the Committee up to date on the 2002 IT Strategic Projects. • The six projects shaded green have either been implemented or are in production mode; the three projects shaded yellow have not o Midas – the complaint tracking system – will be reinstalled following the Cerner upgrade o No industry specific solution for Long-Term Care in Cerner, so system selection is still in process o Cerner Patient Management, Clinical Documentation & Clinical Departmentals are slated for FY2007/2008 implementation, pending completion of upgrade & optimization • Discussion of costs vs project budget o Capital needs will slow, but the project scope, infrastructure requirements and implementation matters resulted in an underestimate of costs – revised estimates will be provided at the time 2007 Strategic IT Plan is presented • No venue to Board for IT development o IT will begin making quarterly status reports through the Finance Committee	***Information Only***	Forwarded to the February 12, 2007, Board of Directors meeting as information • **Steve Tanaka will provide revised budget estimates to the Finance Committee in conjunction with the presentation of the 2007 Strategic IT Plan** • **Standing Finance Committee agenda item will be added for quarterly IT Status reports**
Update on Skilled Nursing Facilities	Steve Gold, SLA for SNF Services, discussed the status of the Skilled Nursing Facilities, utilizing the presentation attached as Addendum B of the Agenda.	***Information Only***	Forwarded to the February 12, 2007, Board of Directors meeting as information
Minutes of ICOC Annual Meeting **December 19, 2006**	The PPH Hospital, Emergency Care, Trauma Center Improvement and Repair Measure Bonds Independent Citizens' Oversight Committee (ICOC) held their annual meeting on Tuesday, December 19, 2006. • Review of expenditures paid for by PPH using bond proceeds during FY2006 o No material exceptions were noted o Report is in the process of being drafted ■ Will be provided upon completion through Finance Committee for Board approval ■ Minutes reviewed by ICOC membership, then forwarded for PPH Board approval via Finance Committee • Bob Hemker acknowledged Tanya Howell's support to the members of the ICOC as PPH Staff Liaison, ensuring that meetings and actions of the ICOC were in compliance with its Policies, Procedures & Guidelines and Bylaws	**MOTION:** By Director Rivera, seconded by Michael Covert and carried to recommend approval of the Minutes of the December 19, 2006, Annual Meeting of the ICOC	Forwarded to the February 12, 2007, Board of Directors meeting with a recommendation for approval

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Agenda Item	Discussion	Conclusion/Action	Follow Up
Agreement to Reimburse PMC Medical Staff for Compensation			
Chief of Staff & Chief of Staff Elect – 1/1/06 to 12/31/08 **Chair – Surgery Department – 9/1/06 to 12/31/08** **Department Chairs for All Other Departments & the QMC Chair – 1/1/06 to 12/31/07**	None	**MOTION:** By Director Rivera, seconded by Michael Covert and carried to approve the Agreements to Reimburse both POM and PMC Medical Staff for Compensation for the periods of time noted. Director Bassett abstained due to her working relationship with Dr. Ben Kanter, Chief of Staff at POM.	Forwarded to the February 12, 2007, Board of Directors meeting with a recommendation for approval
Agreement to Reimburse POM Medical Staff for Compensation			
Chief of Staff, Chief of Staff Elect, QMC Chair, Clinical Service Directors & Section Chiefs – 1/1/07 to 12/31/08	None		
December 2006 & YTD FY2007 Financial Report	Utilizing the presentation included as Addendum F of the agenda packet, Bob Hemker discussed the financial statements: • December was a slightly stronger month both as to volumes and financial performance • Marcia Jackson, Chief Planning Officer, reported that recruitment negotiations are in progress with two OBs for POM • Capitation groups' calendar year financials will settle in March/April, and improvement has been seen in group level performance related to 2006 capitation o Total capitation margin through December was $1.3M actual vs $379K budgeted • Chairman Kleiter commented that we are currently half-way through the fiscal year, noting that we must exceed budget the remainder of the year to reach targeted goals	**MOTION:** By Director Rivera, seconded by Director Greer and carried to approve the December 2006 and YTD FY2007 Financial Report as presented	Forwarded to the February 12, 2007, Board of Directors meeting with a recommendation for approval • **Michael Covert will report back to the Finance Committee regarding hospitalist contracts**
New Finance Committee Meeting Schedule for 2007	Discussion items: • Last Tuesday of the month, or the 4th Tuesday? • Bob Hemker inquired about holding daytime meetings, but time requirements were cited as preventing that occurrence	**MOTION:** By Director Rivera, seconded by Director Greer and carried to approve the 2007 Finance Committee meeting schedule as drafted, with meetings to be held for 5:30 dinner/6:00 meeting on the last Tuesday of each month.	Forwarded to the February 12, 2007, Board of Directors meeting for information • **Secretary Tanya Howell will make public notice of the new schedule**

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AGENDA ITEM	DISCUSSION	CONCLUSION/ACTION	FOLLOW UP
ADJOURNMENT	There being no further business, the meeting was adjourned at 8:05 p.m.	**MOTION:** Seconded and carried for adjournment.	
SIGNATURES: • **COMMITTEE CHAIR** ______________________ T.E. Kleiter • **COMMITTEE SECRETARY** ______________________ Tanya Howell			

FY07 Program Review Calendar

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NEW PROGRAMS/INITIATIVES			SPONSOR(S)
December 2006		Wound Care	Sheila Brown
PROGRAM FOLLOW-UP			**SPONSOR(S)**
February 2007		New Vision Program by Special Care Hospital Management	Mary Oelman
SLA Presentation Order			
1	February 2007	Developing a Cardiovascular Institute	Kim Dodson & Bill Kail
2	April 2007	POM OSP	Diane Key & Bill Kail
3	June 2007	Neurosciences	Marcia Jackson & Kim Colonnelli
4	August 2007	PEDS	Diane Key
5	October 2007	Satellite Centers	Marcia Jackson, Susan Linback & Kim Colonnelli
6	December 2007	Minimally Invasive Surgery	Kim Dodson

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January 2007

Contact	Phone
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Not-for-Profit Healthcare Sector: 2007 Industry Outlook

Short-Term Stability in Calendar 2007, Uncertainty through 2009

Moody's Investors Service
Global Credit Research

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Summary Opinion

Moody's projects stable operating performance and financial position in 2007 for not-for-profit hospitals and health systems, although some overall softening in operating performance from 2006 levels is expected. We maintain an uncertain mid-term outlook for 2008 and 2009 as we believe industry challenges continue to outweigh the positive credit factors.

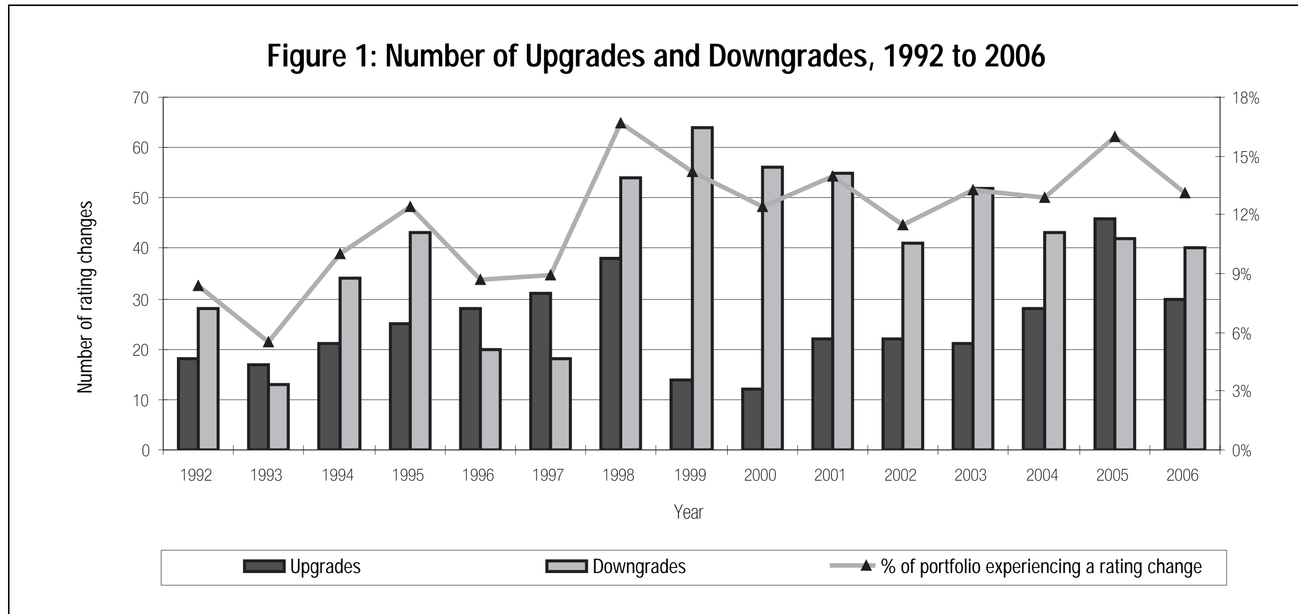
Relatively favorable Medicare rates, stable national and state economies, and better management of financial resources and strategic initiatives support our stable outlook for 2007. While early indications point to a softening in fiscal 2006 performance (based on an analysis of the Moody's-rated portfolio), we believe the industry will show another year of favorable operating margins in fiscal 2006 that will continue into 2007. Operating results are now far stronger than during the depressed years of the late 1990's that followed the implementation of the Balanced Budget Act of 1997 (BBA).

We anticipate that anemic growth in patient volume, increasing competition among providers of both inpatient and outpatient services, and higher capital spending will continue to challenge these favorable results in coming years. We also expect increased federal scrutiny over not-for-profit hospitals' tax-exemption in relationship to the level of charity care provided, and hospital billing practices will demand a larger part of management's time and board agendas.

Our mid-term outlook for the next three years remains uncertain. We anticipate no major overhaul of the health care industry before the next presidential election in November 2008. However, during the interim we believe the industry could still be challenged by lower Medicare reimbursement (compared to the peak in 2005), continued deceleration of increases in commercial insurance rates, growing number of uninsured patients, increased consumerism and physician shortages. These factors will most likely weaken hospital financial performance, further challenging management to control expenses as many of the current and proposed large capital projects financed by debt and cash on hand come on line.

Introduction

Our 2007 industry outlook remains similar to the 2006 outlook – stable for the coming year and uncertain in 2008 and 2009. Our stable outlook for 2007 follows a more typical year of rating activity in 2006, when the number of downgrades (40) outpaced upgrades (30) for a 1.3-to-1 ratio (see Figure 1). The results for 2006 follow the atypical results reported in 2005 when upgrades (46) outpaced downgrades (42). The return to a trend of downgrades outpacing upgrades reflects a projected softening in financial performance in 2007. Nonetheless, profit margins should still be favorable and well ahead of the break-even performance in the difficult years following the BBA.



Factors driving the one-year outlook include the following:

Positive:

1. Medicare rates will remain relatively favorable
2. National and state economies to remain stable
3. Financial performance to remain at higher levels, although early indications show a softening
4. Improving management and governance; new pressures crowd the agenda

Negative:

1. Anemic volume growth
2. Outpatient and inpatient competition increasing
3. Continued higher capital spending with more debt and/or use of cash reserves
4. Continued scrutiny by Congress and other constituents

Factors driving the three-year uncertain outlook include:

Positive:

1. Expectations for no material federal changes in the healthcare industry until after the new administration is elected
2. Stronger physician alignment to enhance loyalty
3. Medical cost growth slowing
4. "Baby Boomer" population increasing demand for hospital services

Negative:

1. Medicare reimbursement remains at risk
2. Deceleration in commercial rate increases due to payer consolidation and employer push back
3. Increasing uninsured population
4. Quality and transparency to lead to greater consumerism and alter demand and reimbursement
5. Physician shortages to intensify
6. Investment portfolios and debt structures becoming riskier
7. Operational risks escalate as new hospital construction comes on line

One-Year Outlook Remains Stable

SHORT-TERM POSITIVE FACTORS:

Medicare Rate Increases Remain Favorable in 2007 Although Lower than 2006

With Medicare representing on average 43% of a given hospital's gross patient revenue, the financial health of most hospitals remains highly dependent on Medicare reimbursement rates and vulnerable to legislative and regulatory changes by the federal government. Fiscal 2007 will be the third consecutive year in which hospitals will receive the full market basket inflationary update. In the past 20 years, the inpatient update factor has averaged approximately two percentage points below the market basket. The average hospital will receive an inpatient rate increase equal to a full market basket inflation of 3.4% (with adjustments, the actual increase will be 3.5%), which, we believe, is good by historical standards, though slightly below the 2006 increase of 3.7%. (Market basket is an inflationary index that measures period-over-period growth in healthcare costs. The Centers for Medicare and Medicaid Services (CMS), which is the government agency that oversees these two federal programs, does not produce a Medicare market basket but individual market baskets are produced for the different payment systems, such as inpatient hospital, skilled nursing facilities, home health and physician fee schedules.)

The decision by Congress to enact a three-year rollout of a new methodology to base certain diagnostic-related groups (DRGs) on costs (vs. charges) and severity of illness was a major event for the industry. The three-year rollout will have a less drastic negative impact on Medicare reimbursement to hospitals than the initial proposal, which would have led to dramatic reductions in rates for certain DRGs, including many related to cardiac surgery, and would have been implemented without a phase-in period. The inability of Congress to implement meaningful reductions is an indication that any meaningful cuts will come after the presidential elections given the divided government that now exists due to thin Democratic majorities in Congress and a Republican president. Further indication of the inability of Congress to pass meaningful cuts was recently evidenced by the decision not to enact Medicare's recommended 5% reduction in physician fees. Physicians will now receive a 1.5% increase in rates if they report various quality data to CMS. We believe the 5% reduction would have likely led to greater physician entrepreneurialism, increasingly difficult on-call coverage issues and growing emergency room volumes as physicians might have closed their practices to Medicare beneficiaries.

National and State Economies Should Remain Stable

The national economy and most state economies expanded favorably in 2006, and should continue to do so in 2007. The nation as a whole performed well with estimated full fiscal year growth in gross domestic product (GDP) of 3.3%, nearly on par with 2005's 3.4%. The 2006 federal deficit fell to a four-year low of $247.7 billion or 22% percent lower than the $318.7 billion imbalance for 2005. Fiscal 2006 denoted the smallest deficit since a $159 billion deficit in 2002. Both spending and tax revenues climbed to all-time highs in 2006 with revenues climbing 11.7% (the second biggest gain in history), outpacing the 7.3% increase in spending.

Will the Housing "Bubble" affect the Healthcare Industry?

Many aspects of the economy, including the housing market, can affect a hospital's financial performance. Moody's Economy.com's recent publication "Housing at the Tipping Point: The Outlook for the U.S. Residential Real Estate Market" states that the U.S. housing market downturn is in full swing. Over 100 metropolitan areas (nearly one-half of the housing stock in the U.S.) are experiencing or are expected to experience declines in housing prices and national median housing prices will decline in 2007. Price declines are expected to continue into 2008 and 2009 in some markets as well.

The housing downturn is expected to restrain economic growth, but not necessarily drive the economy into recession. Consequently, the effects of the soft housing market on the healthcare industry should be modest, particularly in the short-term outlook through 2007. We gain greater comfort knowing that Medicare and commercial and managed care payment rates are in-place and no major revisions in Medicaid enrollment (for most states) are expected through the year.

If, however, the soft housing market has greater-than-expected adverse effects on the labor market and consumer spending (which had been propped up by the housing wealth effect), economic performance could suffer more. Under this scenario, a weak housing market could have acute ramifications for the not-for-profit healthcare industry in the longer-term. For example, under a prolonged economic slowdown, employers would be expected to push even more out-of-pocket healthcare costs to employees, unemployment likely would rise, leading to greater Medicaid and self-pay, and federal and state revenues would moderate, potentially pressuring Medicare and Medicaid budgets. As the housing downturn is in many respects a regional phenomenon – affecting disproportionately the southwest, northeast, Florida, and parts of the upper Midwest – the effects of the soft housing market on healthcare are likely to be more pronounced in these areas.

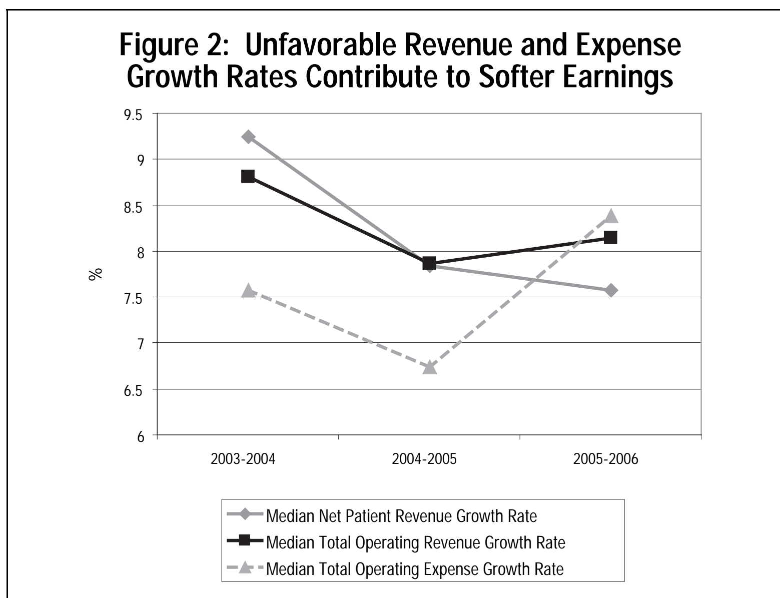
Most states' fiscal health showed improvement in 2006. According to the National Association of State Budget Officers, revenues increased strongly in 2006 with every state either meeting or surpassing its budget. This compares favorably to 2002 when 42 states missed their revenue targets. In 2006, only two states reduced their enacted budgets (Indiana and Louisiana) compared to 37 states in 2003, the height of the economic downturn.

Financial Performance Should Remain at Higher Levels, Although Some Softening Appearing

A preliminary run of medians based on fiscal year 2006 audited financial statements for 102 hospitals (about one-third the sample size of our full-year medians) shows absolute financial performance remains well above the industry's low-point of profitability immediately following the Balanced Budget Act of 1997. Total revenue and total expense growth rates are virtually the same, supporting increases in absolute levels of cash flow.

Some softening is apparent, however. The preliminary results show the median operating margin declined to 2.7% from a stronger 2.9% the prior year, and the median operating cash flow margin declined to 9.4% from 9.8% in the same period. Median net patient revenue growth rates declined to 7.6% in 2006 from 7.8% in 2005 (see Figure 2), which we attribute to growing charity care (or the reclassification of bad debt to charity care) and a deceleration in the growth in commercial rates. Many hospitals may be in the final years of multi-year payer contracts that had large rate increases in year one, followed by lower rate increases in later years, or may be in new contract cycles with lower rates. Additionally, many hospitals that implemented aggressive incremental revenue-cycle strategies in recent years may have reached a plateau of revenue realization. Slower volume trends are another contributor (see discussion on page 9).

Figure 2: Unfavorable Revenue and Expense Growth Rates Contribute to Softer Earnings



Expense growth was a significant contributor to lower margins in 2006. Spending outpaced revenues with expenses growing 8.4% compared to 6.7% in 2005. We believe the higher growth rate in expenses is the culmination of several factors including rising employee health benefit expense, escalating supply expenses (usually the highest expense after salaries and benefits) and increasing bad debt expense due to employers requiring higher co-pays and deductibles. A return to physician employment strategies may also be a contributing factor as new revenues from a newly employed physician may lag the immediate salary expense. Increased depreciation and interest expense from new capital additions are a factor as well.

We also believe that the increase in expense growth likely indicates a return to more "normal" levels. Expense growth was suppressed in recent years as providers cut "low-hanging fruit" from expenses and then enacted expense reductions of a more structural nature, including staff reductions, and improved use of system economies of scales and other measures. Management teams will likely face a more difficult task to control costs going forward, resulting in lower earnings.

The softening in earnings may also represent management's decision to invest in key strategies when financial performance is strong to solidify the hospital's long-term market position. Quality initiatives and heavy investment in information technology are examples of today's strategic investments for longer-term viability, and are two strategies that, we believe, are very important for the future of every American hospital.

Improving Management and Governance; New Items Crowd Agenda

The relatively healthy financial picture enjoyed by many providers reflects a multi-year strategy of an increased focus on the basics of acute care clinical services coupled with favorable rate increases from commercial payers and Medicare. Coincident with this higher strategic focus, we have noticed greater use of formal planning and accountability, including the use of rolling budgets, multi-year forecasting, tying capital spending to cash flow generation and increased capital discipline, as well as the use of outside consultants to both reduce costs and increase revenues. We believe the use of better software tools enables management to take corrective actions quicker as well as make more realistic assumptions about future growth rates.

We are also seeing an increase in board oversight and a strengthening in board expertise through normal board turnover and the desire to add members with healthcare or financial backgrounds. As financial performance has stabilized and improved, boards are showing signs of greater capability and of spending more time on longer-term strategies relating to quality and physician relationships.

We note that a typical hospital chief financial officer's time and skills seem to be stretched over a larger array of issues as the industry continues to be under scrutiny by the federal government and consumer groups, with more external requests for data by regulatory bodies—all of which requires additional resources. Additionally, new strategies such as quality initiatives, documentation of community benefits and physician integration strategies are crowding management "to do" lists. Some providers report difficulty in finding qualified staff accountants or similarly trained individuals given the demand for healthcare financial backgrounds by related industries such as auditing and consulting firms. While we do not formally track turnover rates, personnel changes in the "C-Suite" (CEO, CFO and COO) continue in various markets when hospitals experience difficult financial performance and boards become less tolerant of management assurances of better financial improvement.

SHORT-TERM NEGATIVE FACTORS:

Volume Growth is Anemic

Figure 3: Median Growth Rates in Select Services Show Signs of Slowing

	2004-2005	2005-2006
Admissions	1.40%	0.60%
Outpatient visits	3.60%	2.40%
Outpatient surgeries	2.00%	1.10%

Increased competition, the continued shift of inpatient services to outpatient settings and growing consumerism are contributing factors to anemic volume growth. Based on a sample of 116 hospitals reporting 2006 data, median inpatient admission growth declined materially to 0.6% in 2006 from a healthier 1.4% in 2005. Providers in high growth states of Florida, Nevada, Arizona and Texas report high single digit to low double-digit increases, but most providers are not located in these states. In the rest of the country, providers are generally reporting slight increases in volumes to actual declines.

Outpatient surgeries and even outpatient visits showed slower growth in 2006 given increased competition for these services (see Figure 3). The ability to drive volumes back into the hospital will take on greater urgency as providers report moderation in managed care rates. In prior years, increasing revenue per admission may have been largely driven by unusually high reimbursement rates and masked slowing volume trends. A slowdown in both rates *and* volumes will contribute to softness in financial performance in 2007.

Outpatient and Inpatient Competition Continues

On the outpatient front, in several markets across the country we continue to observe an increase in the opening of independent imaging centers, which follows the past wave of independent ambulatory surgery centers. Imaging centers that offer advanced radiology services such as MRI and CT represent the latest clinical service line to be targeted by for-profit ventures or physicians. This service has been targeted given the relatively low cost of capital investment required and attractive leasing terms for the technology. Imaging services are typically well-reimbursed, and hospitals will now have to compensate for lost revenue related to these services.

Inpatient competition is also heating up, as many providers are expanding into cardiac-related services such as elective cardiac catheterizations. In states where certificate of need (CON) regulation has expired, we have observed a material increase in the number of providers offering open-heart surgery programs given the favorable reimbursement from Medicare, notwithstanding the recent cuts. Construction of "heart institutes" or cardiac centers of excellence continues, either with or without physician investors. Likewise, the expiration of the federally mandated specialty hospital moratorium in August 2006 may also lead to more inpatient competition.

We also expect to see increased inpatient competition in high-growth non-CON states as physicians look to supplement their professional fees with equity interests in new hospitals. We are observing an outbreak of a new type of private for-profit healthcare company that is presenting greater competitive challenges than the large, publicly-traded for-profit hospital companies. These private healthcare companies are funded by hedge funds and private equity sources, and thus do not report publicly to shareholders (see Moody's report, "New For-Profit Hospitals Pose Competitive Challenge for Not-for-Profit Hospitals," December, 2006). We believe the more private nature of these companies, as well as their ability to attract physician investors, allows them to operate more nimbly and quietly, potentially posing an underestimated, competitive threat to not-for-profit hospitals than the well-established public for-profit companies. These new for-profit entities are opening new hospitals primarily in Texas, Arizona and Nevada. In response, not-for- profit hospitals may be forced to accelerate capital spending and embark on new physician alignment strategies, resulting in greater debt and/or less cash reserves to curtail the threat of these new providers.

Higher Capital Spending Should Continue, Creating Rating Pressure

For the first time since Moody's began tracking this metric, the median average age of plant declined to 9.61 years in 2006 from 9.90 years in 2005. Correspondingly, the median capital spending ratio increased to 1.46 times from 1.39 times over the same period, and the median absolute additions to property, plant and equipment increased to $32.1 million in 2006 from $27.7 million in 2005. While maintaining property, plant and equipment is a necessary strategic initiative – and often improves credit over the long run -- it also often creates short-term credit risks, including higher leverage and/or lower liquidity.

We see no abatement in capital spending in 2007. Aging facilities, the need for patient amenities such as private rooms to remain competitive, and the sheer need for additional capacity continue to dominate discussions with management teams regarding capital spending and future debt issuances. Thirteen of the 40 downgrades in 2006 were due specifically to material increases in debt load to fund new patient towers, replacement facilities, major campus overhauls or new hospital construction. For stand-alone hospitals, the cost of a replacement hospital will almost certainly result in a rating downgrade, all other things equal. Cost overruns are also a more common occurrence due to escalating costs of raw materials and high demand for construction labor, resulting in higher use of cash flow or cash reserves or larger debt issuances than initially anticipated.

Scrutiny of the Hospital Industry is Escalating

Hospital charges vs. costs, billing practices to the uninsured, pricing transparency and justifying a hospital's income and property tax exemption status are key subjects that federal and state regulatory bodies continue to scrutinize. The level of scrutiny will only escalate, irrespective of the majority party in Congress or the party of the next president. The increased scrutiny will likely result in a move toward greater pricing transparency, more required charity care, and increased documentation of community benefit to maintain one's property tax-exemption. The recent Congressional Budget Office report that examines the level of community benefit that not-for-profits provide compared to the tax-exempt benefits they receive is another example of the growing focus on hospitals.

Greater accountability in exchange for receipt of federal Medicare reimbursement is another form of regulation. Nearly all providers are reporting various quality measures to CMS in order to receive full Medicare reimbursement and CMS has recently expanded the data requirement to 20 indicators from seven. While the reporting of quality data will likely serve to benefit the consumer over the long-run, it likely represents increased costs in information technology for many providers or an additional use of resources. We believe that the lack of a standardized data set and uniform measurement of clinical outcomes will be a significant challenge for the industry and may result in improper comparisons of providers by payers, physicians and consumers.

We expect that states will closely watch New York's current effort to reduce costs and eliminate underutilized facilities. The recent report released by New York State Commission on Health Care Facilities in the 21st Century has recommended nine hospital closures and 48 mergers or affiliations. If the report's recommendations are followed, 7% of the beds in the state will close. Very recently, New Jersey set up a delegation to commence a similar study. While it remains very difficult to close a hospital given community opposition, we expect over-bedded markets to eventually remove capacity through hospital closures, which would be a credit benefit to the surviving hospitals. We also expect states will watch Massachusetts' progress on universal health care coverage for all residents; Connecticut and Oregon are already considering similar proposals.

Beyond 2007: Long-Term Outlook is Uncertain

POSITIVE FACTORS

1. Expectations of No Material Federal Changes in the Healthcare Industry Until After 2008 Elections

Until a new administration and Congress are in place, we do not foresee any material, legislated changes to overhaul the national healthcare system given Congress's current gridlock. Irrespective of which party is in the majority, a new presidential administration will likely advocate new policies and begin the debate in Congress in the first year after election. The nation's future role in Iraq and the war on terror also presents ambiguity for domestic policies as they will affect spending on other areas. Therefore, the likely absence of any major legislation until 2009 or 2010 is viewed as a credit positive.

2. Stronger Physician Alignment to Enhance Loyalty

Improving physician relationships through various integration strategies will also be a growing strategy for the hospital industry, which should ultimately lead to improved physician loyalty, growing volumes and the alleviation of on-call challenges that many providers are facing. Physicians are seeking a better quality of life, relief from unaffordable malpractice premiums, and a steady income stream. Unlike the mid-1990s, however, we expect that providers will become much more methodical in their physician employment strategies, with a focus on specialists and subspecialists given the growing shortage in certain specialties. A methodical, well-planned physician integration strategy should result in long-term improvement to a hospital's financial profile, although the obvious short-term financial and operational risks need to be carefully managed.

3. Medical Cost Growth Slowing

After many years of double-digit growth, employer health premiums have slowed (7.7% in 2006, from 9.2% in 2005 and 11.2% in 2004).[1] Aggregate healthcare spending has remained level in the last couple of years. Notwithstanding this trend, employers, states, counties, unions, individual consumers and politicians are all citing the growth of medical costs as a core problem that must be alleviated. Consumers' decisions to make health care changes based on out-of-pocket costs, such as changing health care plans, physicians, and pharmaceuticals are all contributing to some slowdown in medical inflation. However, hospitals are reporting that the slowdown in volumes may now be driven by consumers electing to delay various services resulting in a negative impact to financial performance.

4. Baby Boomer Population Increasing Demand for Hospital Services

We believe the long-term demand for hospitalization from an aging population may offset some of the concerns regarding softening volumes. The oldest of the 75 million "baby boomers," nearly 20% of the entire U.S. population, turned 60 years old in 2006, while the youngest turned 42. This is a population that is largely commercially insured and its members are heavy users of hospital services. We believe this huge demand for inpatient and outpatient care will enhance the financial performance of already strong providers who are operating at capacity and may buffer less favorable performance for those who are currently struggling with excess capacity.

1. *The Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits 2006 Annual Survey."*

Negative Factors

1. Medicare Reimbursement Remains at Risk

Similar to our one-year outlook, our longer term three-year outlook is largely based on projected changes to the Medicare budget. Earlier indications from The Medicare Payment Advisory Commission (MedPAC) suggested the possibility of reducing the hospital market basket update in 2008 with hospitals receiving an inpatient and outpatient market basket update minus 0.65 percentage points, in part to account for productivity growth. Reductions to teaching hospitals for educational expenses are also on the drawing board.

Impact of Medicare Part D on Hospital Financial Performance Immaterial, So Far…

While there is ongoing Congressional debate regarding the benefits and costs from the changes to Medicare Part D (prescription drug coverage), to date the impact to hospital performance has been minimal. However, CMS' spending for Part D increased and the potential exists for the funding to come at the expense of provider reimbursement through the form of another Balanced Budget Act. Medicare's drug benefits represent the third highest outlay for Medicare projected 2007 spending, at 19%, following inpatient and outpatient hospital coverage at 30% and managed care spending at 22%.

The surprisingly deep impact of the BBA on hospitals' past financial performance continues to be a discussion point with many providers today. Many hospital professionals fully expect another BBA in the not-so-distant future (see sidebar above). With federal Medicare and Medicaid expenditures representing approximately 19% of the federal budget and no anticipated cuts to the defense budget, any solution to the federal deficit will almost certainly involve cuts to two large healthcare programs. Such a move would most likely have a materially negative impact on hospitals' financial performance. Congress also appears to be increasing its oversight regarding how federal dollars are spent by increasing the number of quality indicators hospitals must now report, as well as requirements that physicians report outcome measures in order to receive a 1.5% bonus payment. Hospitals will also be required to report outpatient quality indicators to Medicare beginning in 2009.

2. Deceleration in Commercial Rate Increases due to Payer Consolidation and Employer Resistance

Rate increases to hospitals from payers vary from market to market, although most providers are reporting rate increases in the mid- to low-single-digit range. This denotes a reduction from recent years of low double-digit rate increases when systems and market leaders utilized their leverage and high occupancy rates to negotiate favorable rate increases and, in effect, to "catch up" from years of suppressed growth in reimbursement rates. Volume softness and the recent spate of large national health insurance mergers have tempered rate increases. We also expect that employer resistance to premium increases will eventually be absorbed by the hospitals through lower rate increases or increased bad debt expense if employers continue to raise co-pay and deductible levels. Similarly, we expect more outpatient reimbursement to shift from a percentage-of-charge basis to a less remunerative fee schedule or ambulatory procedure classification (APCs), similar to Medicare's recently enacted reimbursement methodology.

3. Increasing Uninsured Population

Even though nationwide unemployment levels continue to decline, to 5.1% in 2005 from 5.5% in 2004, the uninsured population continues to increase, to 46.6 million in 2005 from 45.3 million in 2004. The percentage of uninsured rose to 15.9% in 2005 from 15.6% in the prior year. When looking at regional trends, three states saw declines in the percentage of uninsured (New York, Iowa and Idaho) while eight states had material increases (California, Arizona, Utah, Georgia, Florida, South Carolina, Vermont and Delaware). The rest of the states' changes were not statistically significant. (These trends are comparisons of two-year moving averages: 2003-2004 and 2004-2005).[2]

An analysis by the Kaiser Family Foundation indicated that, despite an improving economy and lower unemployment, the number of employers offering healthcare insurance continued to decline and is driving the growth in uninsured. In 2005, 60% of employers offered healthcare, down from 69% in 2000. The growth in health care premiums, which outpaced salary and wage increases, and the decision by employees to opt out of healthcare insurance are growing challenges. Furthermore, across the past five years, there has been a shift towards working for small firms or self-employment and away from working for big businesses.[3] As a result, we expect to see rising charity care and bad debt expense that will impair financial performance until payers or politicians create affordable healthcare insurance for small businesses.

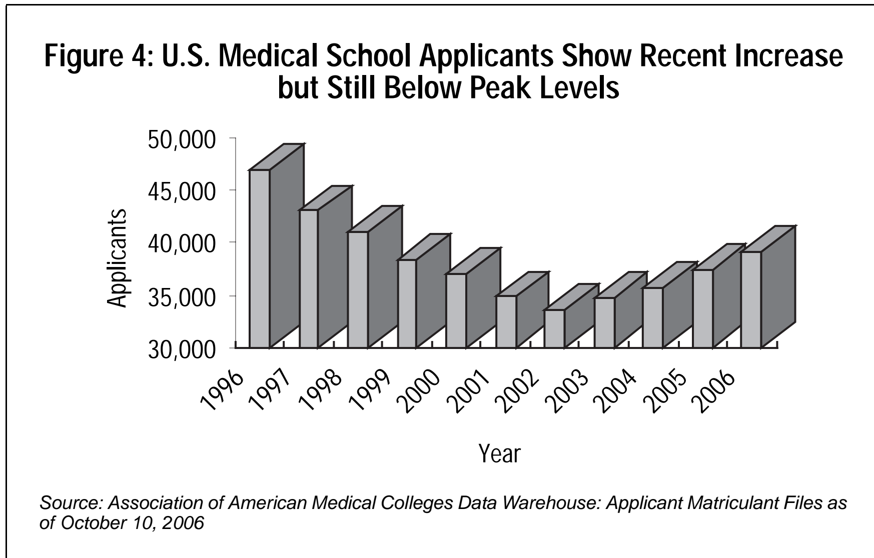
2. US Census Bureau, "Income Poverty, and Health Insurance Coverage in the United States: 2005."
3. The Kaiser Family Foundation, "Why Did the Number of Uninsured Increase in 2005?" October 2006.

4. Quality and Transparency to Lead to Greater Consumerism that Alters Demand and Reimbursement

The push by the public for greater transparency from hospitals in reporting charges, billing practices of the uninsured, and quality outcomes is gaining headline momentum. However, we are not yet seeing a wide-sweeping onset of pay-for-performance (P4P) incentives between payers and providers. We believe it will be several years before most national and regional plans introduce P4P for the majority of their members. Overall, patients continue to choose hospitals and services based on their physician's recommendation or their health plan's in-network coverage. Some insurers have developed a consumer-driven health plan such as Health Savings Accounts (HSAs), which allow patients to gain control of their healthcare spending and engage in a self-rationing of healthcare services based on out-of-pocket costs. Inpatient volumes will likely suffer and bad debt will continue to increase as co-pays and deductibles rise, impairing financial performance along the way. Many providers already report rising bad debt expense due to higher co-pays and deductibles, irrespective of whether the insurance plan is an HSA, and we expect this trend to continue.

5. Physician Shortages Looming

As mentioned above, we expect many hospitals to return to a physician employment strategy driven partially by a predicted physician shortage (see figure 4), especially in the specialty and subspecialty areas. Lower financial rewards and greater interference by payers and regulators has resulted in lower medical school enrollment numbers. We believe hospitals will need to find a fine line between offering enough financial incentives to attract the best physicians and crafting effective productivity standards to ensure that financial performance is not unduly charged with compensating for physician losses.



6. Investment Portfolios and Debt Structures Becoming Riskier

The explosion of financial products that financial intermediaries are making available to providers in an attempt to lower interest costs and increase investment returns continues. Although many of these products and strategies offer advantages, we believe hospitals — particularly financially weaker ones — are likely to experience greater harm in the event of a financial downturn. For example, an operating decline could be exacerbated by a spike in interest rates for a hospital that has a large floating rate debt exposure; a credit deterioration could force a hospital to post collateral against a swap position, further reducing unrestricted liquidity; a shift in the investment markets could result in large losses in arcane hedge fund positions. The use of various derivative products such as interest rate swaps is now in wide use by hospitals across the rating scale, with Baa-rated providers now actively using these products. However, many of these hospitals may not have the critical mass or cash reserves to mitigate an unfavorable move in rates. Likewise, we are seeing providers increasing their allocation to hedge funds or other alternative investments that may have lock-out periods, restricting the hospitals ability to convert the investment into cash. Over the past year, a growing number of Baa-rated providers are also considering alternative investments, all of which are more costly to monitor and may not produce the anticipated higher returns unless careful manager selection and oversight occurs.

7. Operational Risks Escalate as Construction Projects Come on Line

Our final long-term challenge reflects the operational risks associated with new construction projects that come on line in the coming years. Numerous providers have issued debt for patient towers, replacement hospitals and new hospitals that will be finished over the next two to three years. We expect many to face operational challenges as additional staffing is needed and, in many cases, physicians will need to relocate their practices to new facilities. Likewise, many hospitals borrowed large amounts of debt to fund these capital projects at a time when interest rates were low and financial performance was strong. As these projects come on line, we expect to see labor and supply expenses grow during a time of what will likely be lower Medicare reimbursement and deceleration in commercial rates, placing pressure on ratings.

State Listings of Ratings

Portfolio of Freestanding Hospitals/Single-State and Multi-State Systems (as of December 31, 2006)[1]

HOSPITAL/HEALTH SYSTEM[3]	LONG-TERM RATING	SHORT-TERM RATING	OUTLOOK [2]
ALABAMA			
Baptist Health System (Birmingham)	Baa1		S
Children's Hospital of Alabama	A2		S
Cullman Regional Medical Center	Baa3		S
DCH Regional Medical Center	A1		S
Eastern Health System	Baa2		WD
Health Care Auth for Baptist Health (The) AL	A3		S
Helen Keller Hospital	Baa3		S
Huntsville Hospital	A2		S
Jackson Hospital and Clinic	Baa2		S
Marshall County Healthcare Authority	A3		S
Northeast Alabama Regional Medical Center	A3		N
University of Alabama Hospital at Birmingham	A1		N
ARIZONA			
Banner Health System (Phoenix, AZ)	Aa3		S
Phoenix Children's Hospital	Baa3		P
Scottsdale Healthcare	A3		N
Sun Health Corporation	Baa1		S
University Medical Center	Baa1		S
Yavapai Regional Medical Center	Baa2		S
Yuma Regional Medical Center	A2		S
ARKANSAS			
Arkansas Children's Hospital	A1		S
Baxter County Regional Hospital	Baa2		S
Sparks Regional Medical Center	Baa2		N
Washington Regional Medical Center	Baa2		P
CALIFORNIA			
Antelope Valley Healthcare District	Baa2		S
Cedars-Sinai Medical Center	A3		P
Catholic Healthcare West (San Francisco, CA)	A2		S
Chilrdren's Hospital Central California	A3		S
Children's Hospital Of Los Angeles	A3		S
Citrus Valley Health Partners	Ba1		S
City of Hope National Medical Center	A3		S
Community Hospitals of Central California	Baa2		N
Eisenhower Memorial Hospital	A3		P
Fremont-Rideout Health Group	A1		S
Hoag Memorial Presbyterian Hospital	Aa3	VMIG 1	S
Hospital of The Good Samaritan	B1		N
John Muir/Mt. Diablo Health System	A1		S
Kaweah Delta Health Care District	A3		S
Loma Linda University Medical Center	Baa1		S
Lucile Salter Packard Children's Hospital	Aa3		P
Memorial Health Services	A3		S
Palomar Pomerado Health System	A3		S
Scripps Health	A2		S
Sharp Healthcare	Baa1		S
St. Joseph Health System (Orange, CA)	Aa3		S
Stanford Hospitals and Clinics	A2		S
Sutter Health	Aa3		S

[1] Ratings reflect unenhanced ratings and underlying ratings, the latter of which also maintain Aaa-insured ratings.
[2] Positive (P), Negative (N), Stable (S), Uncertain (U), Developing (DEV), Watchlist for Downgrade (WD), Watchlist for Upgrade (WU), Watchlist with Uncertain Direction (WUD).
[3] Organization is listed in the state where it is headquartered; the system may have debt issued in other states that carry the system's rating.

Portfolio of Freestanding Hospitals/Single-State and Multi-State Systems (as of December 31, 2006)[1]

HOSPITAL/HEALTH SYSTEM[3]	LONG-TERM RATING	SHORT-TERM RATING	OUTLOOK [2]
Torrance Memorial Medical Center	A1		S
UC San Diego Medical Center	A1		P
UCSF-Medical Center	A1		P
Washington Hospital Health Care System	A2		N
COLORADO			
Boulder Community Hospital	A2		N
Catholic Health Initiatives (Denver, CO)	Aa2	VMIG 1, P-1	S
Denver Health and Hospital Authority	Baa3		P
Exempla, Inc.	A1		S
Longmont United Hospital	Baa2		S
Memorial Hospital (Colorado Springs)	A3		P
Parkview Medical Center	A3		S
Poudre Valley Health Care	Baa2		S
University of Colorado Hospital Authority	Baa1		S
CONNECTICUT			
Hospital for Special Care	Baa3		S
Middlesex Hospital	A3		P
St. Mary's Hospital	Ba3		N
Windham Community Memorial Hospital	Ba3		WD
DELAWARE			
Beebe Medical Center	Baa1		S
FLORIDA			
Adventist Health System-Sunbelt (Orlando, FL)	A2	VMIG 1	P
Adventist Health System-Sunbelt	A3 (Capital Trust I)		P
All Children's Hospital	A1		S
Baptist Hospital, Inc. & The Baptist Manor, Inc.	Baa1		S
Baptist Health South Florida	Aa3		S
Bay Medical Center	Baa2		N
BayCare Health System	Aa3		S
Cape Canaveral Hospital (Guaranteed by Health First)	A2		S
Citrus Memorial Health System	Baa3		S
Flagler Hospital	A3		S
H. Lee Moffitt Cancer Center	A3		S
Health First	A2		S
Holmes Regional Medical Center (Guaranteed by Health First)	A2		S
Lakeland Regional Health System	A2		S
Lee Memorial Hospital	A2	VMIG 1	WD
Leesburg Regional Medical Center	Baa1		S
South Broward Hospital District	Aa3		S
Mercy Hospital	Baa1		S
Mount Sinai Medical Center (Miami)	Ba1		S
Munroe Regional Health System	A2		S
North Broward Hospital District	A3		S
Orlando Regional Healthcare System	A2		S
Sarasota Memorial Hospital	A2	VMIG 1	S
Shands Teaching Hospital and Clinics	A2		S
South Lake Hospital	Baa2		S
South Lake Hospital (Guaranteed by Orlando Regional Healthcare System)	A2		S
Tallahassee Memorial Regional Medical Center	Baa2		S
Tampa General Hospital	A3		S
University Community Hospital	Baa2		N

[1] Ratings reflect unenhanced ratings and underlying ratings, the latter of which also maintain Aaa-insured ratings.
[2] Positive (P), Negative (N), Stable (S), Uncertain (U), Developing (DEV), Watchlist for Downgrade (WD), Watchlist for Upgrade (WU), Watchlist with Uncertain Direction (WUD).
[3] Organization is listed in the state where it is headquartered; the system may have debt issued in other states that carry the system's rating.

Portfolio of Freestanding Hospitals/Single-State and Multi-State Systems (as of December 31, 2006)[1]

HOSPITAL/HEALTH SYSTEM[3]	LONG-TERM RATING	SHORT-TERM RATING	OUTLOOK [2]
GEORGIA			
Central Georgia Health Systems Obligated Group	Aa3		S
Children's Healthcare of Atlanta	Aa2		S
Memorial Health University Medical Center	A3		WD
Phoebe Putney Memorial Hospital	Aa3		S
Piedmont Healthcare	Aa3		S
South Georgia Medical Center	A2		S
Southeast Georgia Health System	A2		S
Southern Regional Medical Center	Baa1		S
St. Joseph's/Candler Health System	Baa1		S
University Health	A1		S
Wellstar Health System	A1		P
HAWAII			
Hawaii Pacific Health	Baa1		N
Kuakini Health System	Baa2		N
Queen's Health System	A1	VMIG 1, P-1	S
IDAHO			
Portneuf Medical Center	Baa2		N
ILLINOIS			
Advocate Health Care Network	Aa3	VMIG 1	S
Alexian Brothers Health System	A3		S
Anderson Hospital	Baa2		S
Blessing Hospital	A3		S
Condell Medical Center	Baa2		N
DMH Health System	A2		S
Edward Health Services Corporation	A2		S
Elmhurst Memorial Healthcare	A2	VMIG 1	S
Evanston Northwestern Healthcare Corporation	Aa3	VMIG 1	S
Holy Cross Hospital	B2		P
Lake Forest Hospital Foundation	A3		N
Loyola University Health System	Baa2		S
Methodist Medical Center of Illinois	A2		S
Northwest Community Hospital	Aa3	VMIG 1	S
Northwestern Medical Faculty Foundation	Baa1		P
Northwestern Memorial Hospital	Aa2	VMIG 1	S
OSF Healthcare System	A2		S
Palos Community Hospital	Aa3	VMIG 1	S
Proctor Community Hospital	Baa3		S
Provena Health	A3	P-1	S
Resurrection Health Care System	A2		WD
Riverside Health System	A3		S
Rush University Medical Center Obligated Group	A3		S
Sherman Hospital	Baa1		S
St. Vincent de Paul Health System (Guaranteed by Ascension Health)	Aa2	VMIG 1, P-1	S
University of Illinois Health Services	A2		S
INDIANA			
Cardinal Health System Obligated Group	Baa2		S
Clarian Health Partners	A2	VMIG 1	S
Elkhart General Hospital	A1		S
Methodist Hospital (Merrillville)	Ba1		N
Parkview Health System	A1		S
Riverview Hospital	Baa1		S
Sisters of St. Francis Health Services (Mishawaka, IN)	Aa3		S

[1] Ratings reflect unenhanced ratings and underlying ratings, the latter of which also maintain Aaa-insured ratings.
[2] Positive (P), Negative (N), Stable (S), Uncertain (U), Developing (DEV), Watchlist for Downgrade (WD), Watchlist for Upgrade (WU), Watchlist with Uncertain Direction (WUD).
[3] Organization is listed in the state where it is headquartered; the system may have debt issued in other states that carry the system's rating.

Portfolio of Freestanding Hospitals/Single-State and Multi-State Systems (as of December 31, 2006)[1]

HOSPITAL/HEALTH SYSTEM[3]	LONG-TERM RATING	SHORT-TERM RATING	OUTLOOK [2]
IOWA			
Genesis Medical Center	A1		S
Iowa Health System	Aa3		S
Keokuk Area Hospital	Ba3		N
Mercy Hospital	A2		S
Northwest Iowa Health Center (Guaranteed by Sioux Valley Hospitals & Health System)	A1		S
St. Anthony Regional Hospital	Baa3		S
University of Iowa Hospitals	Aa2		N
KANSAS			
Hays Medical Center	A2		S
Hiawatha Hospital Association (Guaranteed by Sisters of Charity of Leavenworth Health System)	Aa2		N
Lawrence Memorial Hospital	A3		S
Med-Map L.L.C. (Guaranteed by Sisters of Charity of Leavenworth Health System)	Aa2		N
Rural Health Resources of Jackson Co. (Guaranteed by Sisters of Charity of Leavenworth Health System)	Aa2		N
Salina Regional Health Center	A1		S
Sisters of Charity of Leavenworth Health System (Leavenworth, KS)	Aa2	VMIG 1	N
Stormont-Vail Health Care	A2		S
KENTUCKY			
Hardin Memorial Hospital	A2		S
Jewish Hospital Health Care Services	A1		WD
King's Daughters' Medical Center	A1		S
Murray-Calloway County Hospital	Baa1		S
LOUISIANA			
Franciscan Missionaries of Our Lady Health System	A1		N
Lafayette General Medical Center	A3		S
Lincoln Health System	Ba1		S
Ochsner Clinic Foundation	A3		WD
Touro Infirmary	Baa2		N
West Jefferson Medical Center	Baa1		S
Woman's Hospital Foundation	A1		S
MAINE			
Maine Health & Higher Educ. Facs. Auth. (Reserve Fund Resolution)	Aa3		S
MARYLAND			
Adventist Healthcare Mid-Atlantic	Baa2		S
Anne Arundel Health System	A3		S
Bon Secours Health System (Marriottsville, MD)	A3		S
Calvert Memorial Hospital	A2		N
Carroll Hospital Center	Baa1		P
Dimensions Health Corporation	B3		N
Doctors' Community Hospital	Baa1		N
Frederick Memorial Hospital	Baa1		S
GBMC Medical Arts Limited Partnership (Guaranteed by Greater Baltimore Medical Center) (Taxable)	A2		S
Greater Baltimore Medical Center	A2	VMIG 1	S
Howard County General Hospital	Baa2		S
Johns Hopkins Hospital	A1	P-1	P
Kennedy Krieger Institute	Baa3		N
LifeBridge Health	A2		S
MedStar Health	Baa1		P
Mercy Medical Center	Baa1		N
Montgomery General Hospital	A3		N

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Portfolio of Freestanding Hospitals/Single-State and Multi-State Systems (as of December 31, 2006)[1]

HOSPITAL/HEALTH SYSTEM[3]	LONG-TERM RATING	SHORT-TERM RATING	OUTLOOK [2]
Peninsula Regional Medical Center	A2		S
Suburban Hospital	A2		S
Union Hospital Of Cecil County	A3		N
University of Maryland Medical System	A3		S
Upper Chesapeake Health System	Baa2		S
MASSACHUSETTS			
Anna Jaques Hospital	Baa3		N
Bay Cove Human Services	Ba2		S
Baystate Medical Center	A1		S
Brigham & Women's Hospital (Guaranteed by Partners Healthcare System)	Aa2		S
CareGroup	Baa1		S
Caritas Christi Health System	Baa3		S
Central New England HealthAlliance	Baa3		S
Children's Hospital (Boston)	Aa2		S
Dana-Farber Cancer Institute	A2		S
Harvard Pilgrim Health Care	Baa3		P
Holyoke Hospital	Ba1		S
Home for Little Wanderers	A3		S
Justice Resource Institute	Ba1		S
Lowell General Hospital	A3		S
Massachusetts Biomedical Research Corporation	Aa3		S
Massachusetts Biomedical Research Corporation (Guaranteed by Massachusetts General Hospital)	Aa2		S
Massachusetts Eye & Ear Infirmary	Ba1		S
Massachusetts General Hospital (Guaranteed by Partners Healthcare System)	Aa2		S
Milford Regional Medical Center	Baa3		S
New England Center for Children	Ba2		S
Newton-Wellesley Hospital (Guaranteed by Partners Healthcare System)	Aa2		S
Northeast Health System	Baa2		S
Partners Healthcare System	Aa2	VMIG 1	S
Saints Memorial Medical Center	Ba1		S
South Shore Hospital	A2		S
SouthCoast Health System	A2		S
The Learning Center for Deaf Children	Ba2		S
UMass Memorial HealthCare	Baa2		S
Vinfen Corporation	Baa3		S
MICHIGAN			
Bronson Methodist Hospital	A2		S
Crittenton Hospital Medical Center	A2		S
Detroit Medical Center	Ba3		S
Dickinson County Healthcare System	Baa3		N
Edward W. Sparrow Obligated Group	A1		S
Garden City Hospital	Ba1		S
Hackley Hospital	Baa1		N
Henry Ford Health System	A1		S
Holland Community Hospital	A2		S
Hurley Medical Center	Ba1		N
Marquette General Hospital	Baa1		N
McLaren Healthcare Corporation	A1		S
Memorial Healthcare	Baa1		S
Mercy Memorial Hospital Corp. Obligated Group	Baa3		S
Mercy Mount Clemens Corp. (Guaranty to Insurer by Trinity Health)	Aa2		S

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[3] Organization is listed in the state where it is headquartered; the system may have debt issued in other states that carry the system's rating.

Portfolio of Freestanding Hospitals/Single-State and Multi-State Systems (as of December 31, 2006)[1]

HOSPITAL/HEALTH SYSTEM[3]	LONG-TERM RATING	SHORT-TERM RATING	OUTLOOK [2]
Mid-Michigan Health	A1		P
Munson Healthcare	A2		P
North Oakland Medical Center	Ba3		N
Oakwood Hospital	A2		S
Pontiac Osteopathic Hospital	Ba1		N
Spectrum Health	Aa3		S
Trinity Health (Novi, Michigan)	Aa2	VMIG 1, P-1	S
University of Michigan Hospitals	Aa2	VMIG 1	S
William Beaumont Hospital	Aa3		S
MINNESOTA			
Allina Health System	A2		S
Fairview Health Services	A2		S
Hazelden Foundation	A3		S
HealthPartners	Baa1		N
HealthEast	Baa3		N
Mayo Foundation	Aa2	VMIG 1	S
North Memorial Health Care	A2		N
St. Cloud Hospital	A2		S
MISSISSIPPI			
Forrest General Hospital	A2		S
Magnolia Hospital	Baa2		N
Memorial Hospital	A2		N
North Mississippi Health Services	Aa3	VMIG 1	S
Rush Foundation Hospital and Medical Foundation	Baa3		S
MISSOURI			
Ascension Health Credit Group (St. Louis, MO)	Aa2	VMIG 1, P-1	S
BJC Health System	Aa2	VMIG 1	S
Boone Hospital Center	A3		S
Capital Region Medical Center	Baa2		S
Heartland Regional Medical Center	A2		S
Jefferson Memorial Hospital	Baa2		S
Sisters of Mercy Health System (St. Louis, MO)	Aa2		S
South Barry County Hospital District (Guaranteed by Sisters of Mercy Health System)	Aa2		S
St. Anthony's Medical Center	A2		P
St. Luke's Health System	A1		S
MONTANA			
Northern Montana Hospital	Baa3		S
St. Peter's Community Hospital	A3		S
NEBRASKA			
BryanLGH Medical Center	A1		S
Children's Healthcare Services	A2		S
Nebraska Medical Center	A1		S
Regional West Medical Center	A3		S
NEVADA			
Washoe Barton Medical Clinic (Guaranteed by Barton Healthcare System)	Baa2		S
Washoe Medical Center	A3		S
NEW HAMPSHIRE			
Catholic Medical Center	Baa1		P
Concord Hospital	A3		S
Crotched Mountain Rehabilitation Center	Baa2	MIG1	N
Elliot Hospital	A3		S
Exeter Hospital	A2		S

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[2] Positive (P), Negative (N), Stable (S), Uncertain (U), Developing (DEV), Watchlist for Downgrade (WD), Watchlist for Upgrade (WU), Watchlist with Uncertain Direction (WUD).
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Portfolio of Freestanding Hospitals/Single-State and Multi-State Systems (as of December 31, 2006)[1]

HOSPITAL/HEALTH SYSTEM[3]	LONG-TERM RATING	SHORT-TERM RATING	OUTLOOK [2]
Memorial Hospital at North Conway	Baa3		S
NEW JERSEY			
AtlantiCare Regional Medical Center (formerly Atlantic City Medical Center)	A2		P
Atlantic Health System	A2		S
Burdette Tomlin Memorial Hospital	A2		S
Capital Health System	Baa1		N
CentraState Medical Center	Baa1		S
Children's Specialized Hospital	Baa3		S
Chilton Memorial Hospital	Baa1		S
Clara Maass Medical Center (Guaranteed by Saint Barnabas Health Care System)	Baa2		S
Columbus Hospital	B3		N
Community Medical Center/Kimball Medical Center/Kensington Manor Care Center (Guaranteed by Saint Barnabas Health Care System)	Baa2		S
Cooper Health System	Baa3		S
Deborah Heart & Lung Center	Baa3		N
Hackensack University Medical Center	A3		N
Holy Name Hospital	Baa2		S
JFK Health System	Baa2		S
Kennedy Memorial Hospital University Medical Center	A2		S
Newton Memorial Hospital	A3		S
Palisades Medical Center of the New York Presbyterian Health System	Baa3		N
Princeton HealthCare System	Baa1		S
Rahway Hospital	Ba2		N
Robert Wood Johnson University Hospital	A2		N
Saint Barnabas Health Care System	Baa2		S
Saint Peter's University Hospital	Baa1		N
Shoreline Behavioral Health Center (Guaranteed by Saint Barnabas Health Care System)	Baa2		S
Somerset Medical Center	Ba1		S
South Jersey Hospital System	Baa1		P
Southern Ocean County Hospital	Baa1		S
Trinitas Health System (formerly St. Elizabeth Hospital/Elizabeth General Hospital)	Baa3		S
NEW MEXICO			
Presbyterian Healthcare Services	Aa3		S
St. Vincent Hospital	Baa1		S
San Juan Regional Medical Center	A3		S
NEW YORK			
Arnot Ogden Medical Center	A3		S
Catholic Health Services of Long Island	Baa1		S
Children's Village	Baa3		S
Community-General Hospital Of Greater Syracuse	Ba3		N
Health Quest Systems	A3		S
Highland Hospital	Baa1		S
Huntington Hospital	Baa1		S
Lenox Hill Hospital	Ba2		N
Memorial Sloan Kettering Cancer Center	Aa2		S
Mount Sinai Hospital	Baa2		S
New York City Health & Hospitals Corporation	A2		S
New York Methodist Hospital	A3		WD
North Shore-Long Island Jewish Health System	A3		N

[1] Ratings reflect unenhanced ratings and underlying ratings, the latter of which also maintain Aaa-insured ratings.
[2] Positive (P), Negative (N), Stable (S), Uncertain (U), Developing (DEV), Watchlist for Downgrade (WD), Watchlist for Upgrade (WU), Watchlist with Uncertain Direction (WUD).
[3] Organization is listed in the state where it is headquartered; the system may have debt issued in other states that carry the system's rating.

Portfolio of Freestanding Hospitals/Single-State and Multi-State Systems (as of December 31, 2006)[1]

HOSPITAL/HEALTH SYSTEM[3]	LONG-TERM RATING	SHORT-TERM RATING	OUTLOOK [2]
Nyack Hospital	B3		N
NYU Hospitals Center	Ba2		P
Orange Regional Medical Center (formerly Arden Hill Hospital-Horton Medical Center)	Baa1		S
Siena Village (Guaranteed by Catholic Health Services of Long Island)	Baa1		S
St. Catherine of Siena Medical Center (Guaranteed by Catholic Health Services of Long Island)	Baa1		S
Staten Island University Hospital	B2		N
Westchester County Medical Center	Ba2		S
Winthrop-South Nassau University System	Baa1		S
NORTH CAROLINA			
Blue Ridge Healthcare System	A3		S
Cabarrus Memorial Hospital (d/b/a NorthEast Medical Center)	Aa3		S
Charlotte-Mecklenburg Hospital Authority (d/b/a Carolinas Healthcare System)	Aa3	VMIG 1	P
Cumberland County Health System (d/b/a Cape Fear Valley Health System)	A3		S
Duke University Health System	Aa3	VMIG 1	P
FirstHealth of the Carolinas	Aa3	VMIG 1	S
Gaston Memorial Hospital (d/b/a CaroMont Health)	A1		S
Halifax Regional Medical Center	Ba3		N
Mission St. Joseph Health System (d/b/a Mission Health)	Aa3	VMIG 1	S
New Hanover Regional Medical Center	A1		N
North Carolina Baptist Hospitals	Aa3	VMIG 1	S
Northern Hospital District of Surry County	Baa3		S
Novant Health	Aa3	VMIG 1	S
Rex Healthcare	A1		S
Union Regional Medical Center	A2		S
University Health Systems of E. Carolina	A1		S
University of North Carolina Hospitals	A1	VMIG 1	S
Wayne Memorial Hospital	A2		S
NORTH DAKOTA			
Altru Health System	Baa2		P
Meritcare Health System	A1		N
OHIO			
Adena Health System (formerly Medical Center Hospital)	A3		S
Catholic Healthcare Partners (Cincinnati, OH)	Aa3	P-1	N
Children's Hospital (Columbus)	Aa2	VMIG 1	S
Children's Hospital Medical Center of Akron	A1		S
Cleveland Clinic Health System	Aa3	VMIG 1	S
Doctors OhioHealth (Guaranteed by OhioHealth)	Aa3		S
East Liverpool City Hospital	A3		S
Fairview Health System (Member of Cleveland Clinic Health System)	Aa3		S
Fairfield Medical Center	Baa1		N
Firelands Community Hospital	A3		N
Forum Health System	B1		WD
Health Alliance of Greater Cincinnati	A1		S
Kettering Medical Center Network Obligated Group	A2		S
Lakewood Hospital (Affiliate of Cleveland Clinic Health System)	A1		S
Marietta Area Health Care	Baa2		S
MetroHealth System	A3		S
Miami Valley Hospital	Aa3	VMIG 1	N
Middletown Regional Hospital	A3		WD
OhioHealth (Grant/Riverside Methodist Hospitals)	Aa3		S

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Portfolio of Freestanding Hospitals/Single-State and Multi-State Systems (as of December 31, 2006)[1]

HOSPITAL/HEALTH SYSTEM[3]	LONG-TERM RATING	SHORT-TERM RATING	OUTLOOK [2]
Southwest General Hospital	A2		S
St. Luke's Hospital	A2		S
Summa Health System	Baa1		P
Trinity Health System	A3		N
UHHS/CSAHS-Cuyahoga, Inc. & CSAHS/UHHS-Canton, Inc.	Baa2		S
Union Hospital	Baa1		N
University Hospitals Health System	A3		P
Upper Valley Medical Center Hospital	Baa1		P
OKLAHOMA			
Integris Health	Aa3		S
Norman Regional Hospital Authority	Baa2		N
Saint Francis Health System	Aa3		S
St. John Medical Center	Aa3	VMIG 1	S
Stillwater Medical Center	Baa1		S
Valley View Regional Medical Center	Ba1		S
OREGON			
Cascade Health Services	A1		S
Legacy Health System	A1	VMIG 1	S
Willamette Falls Community Hospital	Baa3		S
PENNSYLVANIA			
Allegheny General Hospital (Guaranteed by West Penn Allegheny Health System)	Ba3		S
Catholic Health East (Newtown Square, PA)	A1		S
Chester County Hospital	Baa2		S
Children's Hospital of Philadelphia	Aa2	VMIG 1	S
Community Medical Center	Baa2		N
Crozer-Chester Medical Center	Baa2		S
Doylestown Hospital	A3		S
Excela Health	A3		S
Forbes Health System (Guaranteed by West Penn Allegheny Health System)	Ba3		S
Geisinger Health System Foundation	Aa3	VMIG 1	P
Good Samaritan Hospital	Baa2		S
Good Samaritan Medical Center of Johnstown (Guaranteed by Memorial Medical Center)	Baa1		N
Hamot Health Foundation	A2		S
Hazleton General Hospital	Ba2		N
Hazleton-St. Joseph Medical Center	Ba3		N
Heritage Valley Health System (formerly Valley Health System)	A1		S
Highlands at Wyomissing (Guaranteed by Reading Hospital & Medical Center)	Aa3		S
Holy Redeemer Hospital	Baa2		N
Jefferson Health System	Aa3	VMIG 1	S
Jefferson Regional Medical Center (formerly South Hills Health System)	Baa1		P
KidsPeace, Inc.	B2		S
Lancaster General Hospital	Aa3		S
Lehigh Valley Health Network	A1		S
Lewistown Hospital	Baa1		S
Lower Bucks Hospital	B2		S
Masonic Homes of the Grand Lodge	Baa1		S
Memorial Medical Center (formerly Conemaugh Valley Memorial Hospital)	Baa1		N
Monongahela Valley Hospital	A3		S
Montgomery Hospital	Baa3		S

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Portfolio of Freestanding Hospitals/Single-State and Multi-State Systems (as of December 31, 2006)[1]			
HOSPITAL/HEALTH SYSTEM[3]	LONG-TERM RATING	SHORT-TERM RATING	OUTLOOK [2]
Ohio Valley General Hospital	Baa2		S
Pine Run Retirement Community	Baa2		N
Pinnacle Health	A2		S
Reading Hospital And Medical Center	Aa3		S
Sacred Heart Health System	Ba3		WD
St. Vincent Hospital	Baa1		S
Somerset Hospital	Baa2		S
St. Luke's Hospital and Health Network	Baa1		S
Temple University Children's Medical Center (Guaranteed by Temple University Hospital)	Baa2		S
Temple University Hospital	Baa2		S
University of Pennsylvania Health System	A1		S
University of Pittsburgh Medical Center	Aa3	VMIG1	S
The Washington Hospital	Baa1		S
WellSpan Health	Aa3		S
West Penn Allegheny Health System	Ba3		S
Western Pennsylvania Hospital (Guaranteed by West Penn Allegheny Health System)	Ba3		S
Windber Medical Center of Johnstown (Guaranteed by Memorial Medical Center)	Baa1		N
PUERTO RICO			
Hospital De La Conception (Guaranteed by Ascension Health)	Aa2		S
RHODE ISLAND			
Lifespan Rhode Island Obligated Group	A3		S
South County Hospital	Baa2		N
St. Joseph Health Services of Rhode Island	Baa3		N
Westerly Hospital	Ba2		N
SOUTH CAROLINA			
CareAlliance Health Services	A3		S
Conway Hospital	A3		S
Greenville Hospital System	Aa3		N
Lexington County Health Services District	A2		S
Palmetto Health Alliance	Baa1		S
Self Regional Healthcare	A2		S
SOUTH DAKOTA			
Avera Health	A1		S
Evangelical Lutheran Good Samaritan Society	A3		S
Prairie Lakes Health Care System	Baa1		S
Rapid City Regional Hospital	A1		S
Sioux Valley Hospital & Health System	A1	VMIG 1	S
TENNESSEE			
Baptist Health System of East Tennessee Hospital	Baa3		WD
Blount Memorial Hospital	Baa1		P
Cookeville Regional Medical Center	A3		S
East Tennessee Children's Hospital	Baa1		N
Erlanger Medical Center	A3		N
Jackson-Madison County General Hospital	A1		S
Methodist Healthcare	A2		S
Mountain States Health Alliance	Baa2		S
Northcrest Medical Center	Baa3		S
University Health System (Knoxville)	Baa1		S
TEXAS			
Baylor Health Care System	Aa3		P
Children's Medical Center of Dallas	Aa3		S

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Portfolio of Freestanding Hospitals/Single-State and Multi-State Systems (as of December 31, 2006)[1]

HOSPITAL/HEALTH SYSTEM[3]	LONG-TERM RATING	SHORT-TERM RATING	OUTLOOK [2]
CHRISTUS Health (Dallas, TX)	A1		S
Cook Children's Medical Center	A1		S
East Texas Medical Center Regional Healthcare System	Ba2		N
Ector County Hospital (Medical Center Hospital)	A3		S
Good Shepherd Medical Center	Baa2		P
Harris County Hospital District	Baa2		S
Hunt Memorial Hospital District	A3		S
Irving Hospital Authority	A1		P
McKenna Memorial Hospital	Baa2		S
Memorial Hermann Hospital System	A2		S
Methodist Hospitals of Dallas	Aa3		N
Mission Hospital	Baa2		N
Mother Frances Health System	Baa1		S
Northeast Medical Center Hospital	Baa2		S
Richardson Regional Medical Center	Baa2		N
Scott & White Memorial Hospital & Scott Sherwood & Brindley Foundation	Aa3		N
Shannon Health System & Shannon Med. Ctr	Baa3		N
Tarrant County Hospital District (JPS Health Network)	A2		P
Texas Children's Hospital	Aa2		S
Texas Health Resources	Aa3		S
Texas Medical Center Central Heating and Cooling Services Corporation	Aa3		S
Tomball Regional Hospital	Baa3		S
United Regional Health Care System	A3		S
Wilson N. Jones Memorial Hospital	B1		N
UTAH			
IHC Hospitals, Inc. (Salt Lake City, UT)	Aa1	VMIG 1	S
University of Utah Hospital (Moral Obligation Bonds)	Aa2		S
VERMONT			
Fletcher Allen Health Care	Baa1		S
VIRGINIA			
Alexandria Medical Properties (Guaranteed by Inova Health System)	Aa2		S
Arlington Hospital	A2		S
Augusta Health Care, Inc.	A1		S
Carilion Health System	Aa3		S
Centra Health	A2		N
Chesapeake General Hospital	A3		S
Children's Hospital of The King's Daughters	A2		S
Inova Health System	Aa2	VMIG 1	S
Johnston Memorial Hospital	A2		N
Martha Jefferson Hospital & MJH Foundation	A2		S
MediCorp Health System	A3		S
Potomac Hospital	A3		S
Prince William Hospital	A2		S
Riverside Health System	Aa3	VMIG 1	S
Rockingham Health Care, Inc.	Baa1		S
Sentara Healthcare	Aa2	VMIG 1, P-1	S
Valley Health System	Aa3		S
Virginia Commonwealth Univ. Health System	A1		S
WASHINGTON			
Children's Hospital & Regional Medical Center	Aa3		S
Evergreen Hospital Medical Center	A3		S
Kadlec Hospital	Baa1		S

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Portfolio of Freestanding Hospitals/Single-State and Multi-State Systems (as of December 31, 2006)[1]			
HOSPITAL/HEALTH SYSTEM[3]	LONG-TERM RATING	SHORT-TERM RATING	OUTLOOK [2]
MultiCare Health System	A1		N
Overlake Hospital Medical Center	Baa3		S
Providence Health System (Seattle, WA)	Aa2		S
Skagit Valley Hospital	Baa2		S
Southwest Washington Medical Center	A2		S
Stevens Healthcare	Ba2		N
WEST VIRGINIA			
Cabell Huntington Hospital	A3		S
Charleston Area Medical Center	A2		S
Davis Memorial Hospital	Baa2		N
Fairmont General Hospital	Ba2		N
Princeton Community Hospital	B2		S
Weirton Medical Center	Baa3		N
West Virginia University Hospitals, Inc.	A2		S
WISCONSIN			
Agnesian Healthcare, Inc	A3		S
Bellin Memorial Hospital	A3		S
Children's Hospital and Health System, Inc.	Aa3		S
Gundersen Lutheran	A2		P
Mercy Health System Corporation of Janesville	A2		S
Meriter Hospital	A2		P
Monroe Clinic	A3		S
ProHealth Care Obligated Group	A1		S
University of Wisconsin Hospitals & Clinics	A1		S
Aspirus Wausau Hospital	A2		N
Wheaton Franciscan Services	A3		N
WYOMING			
Wyoming Medical Center	A3		P

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Special Comment:

Fiscal Year 2005 Not-for-Profit Health Care Medians: A Record Year of Performance for the Sector, August 2006 (98491)

Not-for-Profit Hospitals: The Importance of Cash, March 2006 (97008)

Long-term Credit Impact of Medicaid Reform by States on Not-for-Profit Hospitals Uncertain, October 2006 (100234)

Not-for-Profit Hospitals: 2006 State of the States, February 2006 (96709)

New York State "Closure" Commission Recommendations Not Expected To Have Immediate Impact On Credit Ratings, December 2006 (100964)

Landmark Health Insurance Legislation in Massachusetts Expected to Have Positive Impact on Hospitals, May 2006 (97272)

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Information Systems
2002 Strategic Plan Update

Finance Committee

January 23, 2007

PALOMAR POMERADO HEALTH
SPECIALIZING IN YOU

2002 IT Strategic Projects

Lawson • Financials •Human Resources •Materials Mgmt	**Avega** • Decision Support •Contract Mgmt •Cost Accounting	**MIDAS** • Quality Management
API • Time & Attendance	**Carex-Vision** • Food and Nutrition	**Long Term Care** •* System Selection
PACS • Cerner	**Website-Intranet** • Web Network •PPH.ORG	**Cerner** • Patient Management •Clinical Documentation •Clinical Departmentals

PALOMAR POMERADO HEALTH
SPECIALIZING IN YOU

2002 IT Strategic Plan Project Status

Financial Systems (Lawson) - Installed

Phase 1

General Ledger, Accounts Payable,
Fixed Assets, Materials Management
Live- February 2004 (v8.1 Upgrade FY08)

Phase 2

Human Resources, Payroll, Time & Attendance,
Employee/Manager Self Service
Live- August 2004 (v8.1 Upgrade FY08)

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2002 IT Strategic Plan Project Status

Decision Support (Avega) Installed

Contract Management, Cost Accounting,
Decision Support
Live- April 2004
***Budgeting -SRC**

Quality Management (Midas) Pending

Current Midas implementation revisited
Re-install scheduled post Cerner
Upgrade – Calendar Q1 2007

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2002 IT Strategic Plan
Project Status

Dietary (Carex/Vision) Installed
User training in process.
Live- February 2004

PACS Installed
Cerner ProVision PACS system
Live- May 2005

Web Site & Intranet Under Construction
Web network infrastructure installed
Live- August 2005

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2002 IT Strategic Plan
Cerner Phase 1Project Status

Enterprise Patient Management Under Construction
Registration, Scheduling, Medical Records, Lab, Pharmacy, Radiology, OR, ER, Clinical Orders, Results & Documentation, Patient Billing, Clinical Reporting
Live- October 2004
Upgrade- Jan. 25, 2007
Cerner Clinical Doc. Optimization- FY07/FY08
* System selection- Long Term Care

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2002 IT Strategic Plan
Cerner Phase II Projects

- Computerized Physician Order Entry
- Document Imaging
- Medical Transcription
- Initial MD Documentation
- Cardiology Management
- ICU Management
- Anesthesia Management
- Electronic Medical Record (EMR) enhancement

Hold-Pending Cerner Upgrade and Optimization

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2002 IT Strategic Plan
Challenges

- Project Pre-Planning
- Workflow Redesign
- Project Scope
- Project Resourcing
- Shifting/Competing Priorities
- Lack of a Project Management Methodology
- Changing operational environment

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2002 Projects Budget

- Approved Ten Year Project Budget
  Includes Capital & Operational Costs
- Total 10 year cost $44.5 M
- Capital Costs to Date $30.5 M
- Costs to Date Includes:
  Hardware, software, consulting, training, travel, development teams, supplies, construction

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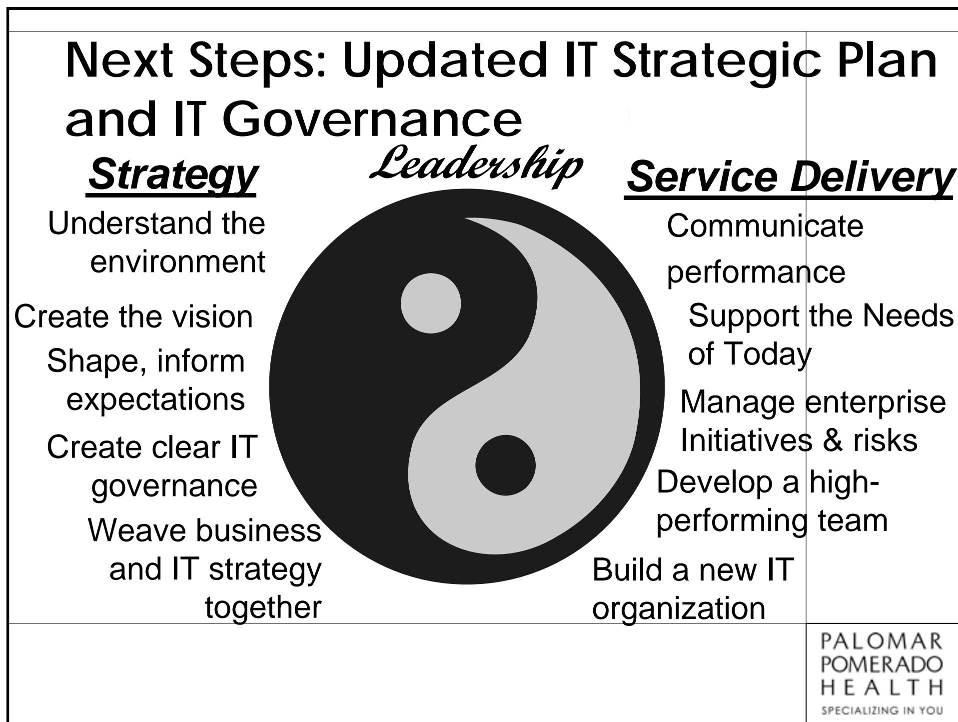

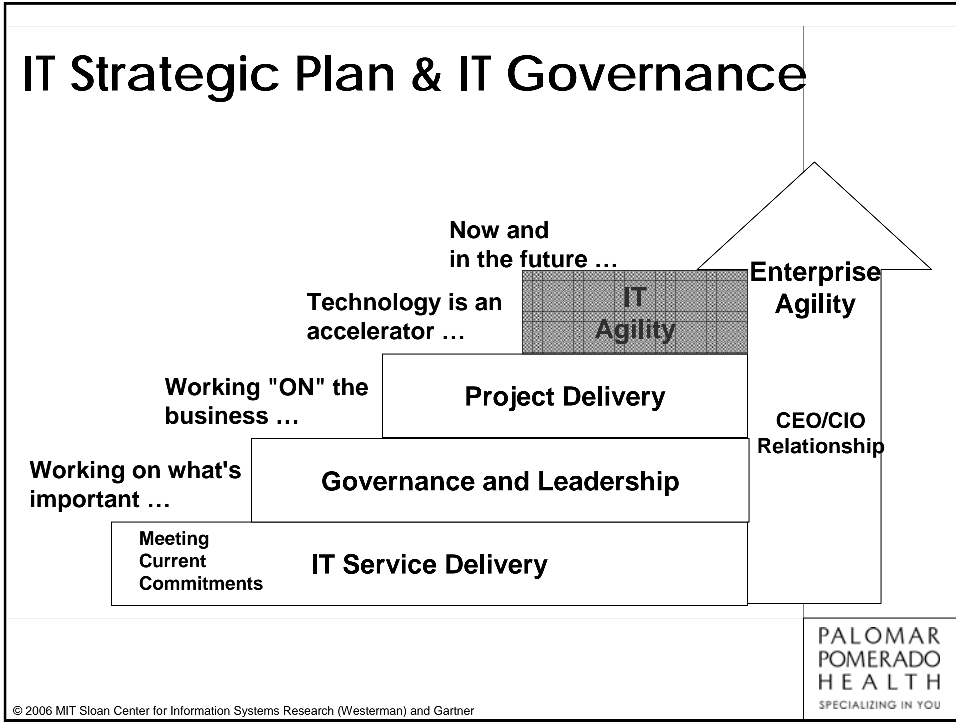
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Now and
in the future …
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accelerator …
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Enterprise
Agility
Working "ON" the
business …
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CEO/CIO
Relationship
Working on what's
important …
Governance and Leadership
Meeting
Current
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