KAISER PERMANENTE®

Mid-Atlantic Permanente Medical Group, P.C.
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

February 4, 2016

Ms. Ruby Potter
Health Facilities Coordinator
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

RE: Certificate of Need Application to Add One Operating Room to an Existing Freestanding Ambulatory Surgery Center in Baltimore County

Dear Ms. Potter,

Enclosed are six (6) copies of the Kaiser Foundation Health Plan of the Mid-Atlantic States' Certificate of Need application to add one operating room to the ambulatory surgery center located at Kaiser Permanente's South Baltimore County Medical Center in Halethorpe, Maryland.

A Letter of Intent was filed with MHCC on December 4, 2015.

Thank you for your favorable consideration of this application.

Sincerely,

Michael C. Rogers
Executive Director, Strategic Planning

2101 East Jefferson Street
Rockville, Maryland 20852

STATE OF MARYLAND

Craig P. Tanio, M.D.
CHAIR

Ben Steffen
EXECUTIVE DIRECTOR

For internal staff use:

MARYLAND HEALTH CARE COMMISSION

MATTER/DOCKET NO.

DATE DOCKETED

INSTRUCTIONS: GENERIC APPLICATION FOR CERTIFICATE OF NEED (CON)

Note: Specific CON application forms exist for hospital, comprehensive care facility, home health, and hospice projects. This form is to be used for any other services requiring a CON.

ALL APPLICATIONS MUST FOLLOW THE FORMATTING REQUIREMENTS DESCRIBED IMMEDIATELY BELOW. NOT FOLLOWING THESE FORMATTING INSTRUCTIONS WILL RESULT IN THE APPLICATION BEING RETURNED.

Required Format:

Table of Contents. The application must include a Table of Contents referencing the location of application materials. Each section in the hard copy submission should be separated with tabbed dividers. Any exhibits, attachments, etc. should be similarly tabbed, and pages within each should be numbered independently and consecutively. **The Table of Contents must include:**

- **Responses to PARTS I, II, III, and IV of the this application form**
- **Responses to PART IV must include responses to the standards in the State Health Plan chapter that apply to the project being proposed..**
  - All Applicants must respond to the Review Criteria listed at 10.24.01.08G(3)(b) through 10.24.01.08G(3)(f) as detailed in the application form.
- **Identification of each Attachment, Exhibit, or Supplement**

Application pages must be consecutively numbered at the bottom of each page. Exhibits attached to subsequent correspondence during the completeness review process shall use a consecutive numbering scheme, continuing the sequencing from the original application. (For example, if the last exhibit in the application is Exhibit 5, any exhibits used in subsequent responses should begin with Exhibit 6. However, a replacement exhibit that merely replaces an

exhibit to the application should have the same number as the exhibit it is replacing, noted as a replacement.

SUBMISSION FORMATS:

We require submission of application materials and the applicant's responses to completeness questions in three forms: hard copy; searchable PDF; and in Microsoft Word.

- **Hard copy:** Applicants must submit six (6) hard copies of the application to:
  Ruby Potter
  Health Facilities Coordinator
  Maryland Health Care Commission
  4160 Patterson Avenue
  Baltimore, Maryland 21215

- **PDF:** Applicants must also submit *searchable* PDF files of the application, supplements, attachments, and exhibits.[1] All subsequent correspondence should also be submitted both by paper copy and as *searchable PDFs*.

- **Microsoft Word:** Responses to the questions in the application and the applicant's responses to completeness questions should also be electronically submitted in Word. Applicants are strongly encouraged to submit any spreadsheets or other files used to create the original tables (the native format). This will expedite the review process.

Applicants are strongly encouraged to submit any spreadsheets or other files used to create the original tables (the native format). This will expedite the review process.

PDFs and spreadsheets should be submitted to ruby.potter@maryland.gov and kevin.mcdonald@maryland.gov.

Note that there are certain actions that may be taken regarding either a health care facility or an entity that does not meet the definition of a health care facility where CON review and approval are not required. Most such instances are found in the Commission's procedural regulations at COMAR 10.24.01.03, .04, and .05. Instances listed in those regulations require the submission of specified information to the Commission and may require approval by the full Commission. Contact CON staff at (410) 764-3276 for more information.

A pre-application conference will be scheduled by Commission Staff to cover this and other topics. Applicants are encouraged to contact Staff with any questions regarding an application.

[1] PDFs may be created by saving the original document directly to PDF on a computer or by using advanced scanning technology

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: **Kaiser Permanente South Baltimore County Medical Center**

Address:

1701 Twin Springs Rd.	**Halethorpe**	**21227**	**Baltimore County**
Street	City	Zip	County

2. Name of Owner Kaiser Foundation Health Plan Of The Mid-Atlantic States, Inc

If Owner is a Corporation, Partnership, or Limited Liability Company, attach a description of the ownership structure identifying all individuals that have or will have at least a 5% ownership share in the applicant and any related parent entities. Attach a chart that completely delineates this ownership structure.

3. APPLICANT. *If the application has a co-applicant, provide the following information in an attachment.*

Legal Name of Project Applicant (Licensee or Proposed Licensee):

Kaiser Foundation Health Plan Of The Mid-Atlantic States, Inc

Address:

2101 E. Jefferson Street	**Rockville**	**20852**	**MD**	**Montgomery**
Street	City	Zip	State	County
Telephone:	**301-816-6440**			

KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC

4. NAME OF LICENSEE OR PROPOSED LICENSEE, if different from the applicant:

5. LEGAL STRUCTURE OF APPLICANT (and LICENSEE, if different from applicant).

Check ☑ or fill in applicable information below and attach an organizational chart showing the owners of applicant (and licensee, if different).

A.	Governmental	☐	
B.	Corporation		
	(1) Non-profit	☒	
	(2) For-profit	☐	
	(3) Close	☐	State & Date of Incorporation Washington, DC, October 9, 1980
C.	Partnership		
	General	☐	
	Limited	☐	
	Limited Liability Partnership	☐	
	Limited Liability Limited Partnership	☐	
	Other (Specify):		
D.	Limited Liability Company	☐	
E.	Other (Specify):		
	To be formed:	☐	
	Existing:	☒	

6. PERSON(S) TO WHOM QUESTIONS REGARDING THIS APPLICATION SHOULD BE DIRECTED

A. Lead or primary contact:

Name and Title: Adam Pender, Senior Planning Consultant

Company Name **Kaiser Foundation Health Plan of the Mid-Atlantic States**

Mailing Address:

Delivery System Planning
2101 E. Jefferson Street **Rockville** **20852** **MD**
Street City Zip State

Telephone: 301.816.6827

E-mail Address (required): **adam.pender@kp.org**

Fax: 301-816-7119

If company name is different than applicant briefly describe the relationship

B. Additional or alternate contact:

Name and Title: Kristin Bear, Senior Counsel

Company Name Kaiser Foundation Hospitals / Health Plan
Mailing Address:
Provider Operations Practice Group | Legal Department
2101 E. Jefferson Street 7th Floor MD Rockville 20852 MD
Street City Zip State

Telephone: (301) 816-6640
E-mail Address (required): Kristin.Bear@kp.org

Fax: 301-816-7275

If company name is different than applicant briefly describe the relationship

B. Additional or alternate contact:

Name and Title: Michael Rogers, Executive Director, Strategic Planning

Company Name Kaiser Foundation Health Plan of the Mid-Atlantic States
Mailing Address:
2101 E. Jefferson Street Rockville 20852 MD
Street City Zip State

Telephone: 301-816-6622
E-mail Address (required): michael.c.rogers@kp.org

Fax: 301-816-7119

If company name is different than applicant briefly describe the relationship

B. Additional or alternate contact:

Name and Title: Andrew L. Solberg President

Company Name A.L.S. Healthcare Consultant Services
Mailing Address:

5612 Thicket Lane	**Columbia**	**21044**	**MD**
Street	City	Zip	State

Telephone: 410-730-2664
E-mail Address (required): asolberg@earthlink.net

Fax: 410-730-6775

If company name is different than applicant briefly describe the relationship **Consultant**

7. TYPE OF PROJECT

The following list includes all project categories that require a CON pursuant to COMAR 10.24.01.02(A). Please mark all that apply in the list below.

If approved, this CON would result in (check as many as apply):

(1) A new health care facility built, developed, or established ☐
(2) An existing health care facility moved to another site ☐
(3) A change in the bed capacity of a health care facility ☐
(4) A change in the type or scope of any health care service offered by a health care facility ☒
(5) A health care facility making a capital expenditure that exceeds the current threshold for capital expenditures found at: http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/con_capital_threshold_20140301.pdf ☐

8. PROJECT DESCRIPTION

A. Executive Summary of the Project: The purpose of this BRIEF executive summary is to convey to the reader a holistic understanding of the proposed project: what it is, why you need to do it, and what it will cost. A one-page response will suffice. Please include:

(1) Brief Description of the project – what the applicant proposes to do
(2) Rationale for the project – the need and/or business case for the proposed project
(3) Cost – the total cost of implementing the proposed project

Addition of one OR to an existing two OR ASF

B. Comprehensive Project Description: The description should include details regarding:

(1) Construction, renovation, and demolition plans
(2) Changes in square footage of departments and units
(3) Physical plant or location changes
(4) Changes to affected services following completion of the project
(5) Outline the project schedule.

Please see following page

Project Description

I. Overview of Kaiser Permanente

Kaiser Permanente is America's largest private integrated healthcare delivery system, providing health care to 10 million members in eight states and the District of Columbia. In the Mid-Atlantic States Region, "Kaiser Permanente" (a trade name) comprises Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP) and the Mid-Atlantic Permanente Medical Group (MAPMG), a multi-specialty group practice of more than 1200 physicians with which KFHP exclusively contracts to meet the medical care needs of approximately 600,000 Kaiser Permanente members in Maryland, Virginia, and the District of Columbia. KFHP is a non-profit corporation whose sole member is Kaiser Foundation Health Plan, Inc., and was formed on or about October 9, 1980.

Kaiser Permanente (or "Kaiser") has over 308,000 members in Maryland and owns and operates 17 outpatient medical office buildings in Maryland to provide care directly to Kaiser's members. In addition, Kaiser contracts with community practitioners and facilities to provide care that Kaiser does not provide internally or to meet the geographic access needs of our members. Kaiser provides some ambulatory surgical services internally at our Kensington Ambulatory Surgery Facility, but also contracts with hospitals and ambulatory surgical facilities for these services.

Nationally, Kaiser's owned and operated medical centers focus on creating an integrated care experience to promote cost-effectiveness, efficiency, quality of care, and member convenience and satisfaction. At these centers, virtually all pharmacy, diagnostic, and laboratory services needed to support the centers are performed by Kaiser Permanente directly. Co-location of primary and specialty care with ancillary services at full-service medical centers, all supported by advanced technology, is a key component of the Kaiser Permanente vision of comprehensive and affordable health care. A high level of integration and internalization of services at our medical centers allows patients to have multiple services in the course of one visit to a center, permits better coordination of care, and consolidates our members' medical information in one place – our electronic medical records, which tie our integrated services together.

As part of its commitment to high quality of care, Kaiser Permanente has made a significant investment in developing its secure Electronic Health Record ("EHR") system, KP HealthConnect™, to support the delivery of care to its members and to enhance communications among the medical professionals who serve them. This EHR system allows Kaiser physicians to access a patient's electronic medical record at any Kaiser center where the patient receives care. The system includes physician order entry for laboratory and radiology tests as well as electronic prescribing capability connected with Kaiser pharmacy systems. This system allows physicians to send diagnostic test orders and receive test results electronically, which creates efficiencies in obtaining rapid test results. Test results are displayed in the patient's EHR and are available to all Kaiser treating physicians with EHR access, preventing duplicate testing and enhancing patient safety. The EHR system performs other patient-safety functions

as well, such as automated clinical decision support for adverse drug event prevention, drug-allergy checking, alerts when preventive health screenings are due, and medication adherence monitoring. This system has increased efficiency, reduced errors, and improved patient care and patient safety.

II. Planning for Improvements in Ambulatory Surgery

To better realize these benefits of health care integration in the Mid-Atlantic States Region, Kaiser established new medical offices in Maryland that include comprehensive primary and specialty outpatient care, diagnostic services and pharmacy services in one building. Expansion of the ambulatory surgery access represents an integral component of Kaiser's continuum of services to its members. In addition to better integration of services, Kaiser's plans for new medical offices are also intended to support expected membership growth in Maryland and improve geographic access for our membership. The ambulatory surgery facilities are a small, but integral part of these new medical offices. Co-location of ambulatory surgery with primary and specialty care and diagnostic services increases cost-effectiveness and is convenient to our members and to our physicians practicing at those centers. Internalizing more surgical procedures also enhances cost-effectiveness. In addition, this allows better coordination of health care services, supported by Kaiser's EHR systems, improving quality and patient safety.

III. Description of Ambulatory Surgery Facility Project

Kaiser currently operates eight existing medical offices in Baltimore City and three surrounding counties (Anne Arundel, Baltimore, and Howard). We have recently leased space in Harford County that will open in 2017.

In 2010, Kaiser purchased a 9.4 acre site in order to establish a larger, more comprehensive Kaiser Permanente South Baltimore County medical center. This was the eighth site to serve Kaiser members in the greater Baltimore area. Kaiser is the sole tenant in the building. The new medical center includes outpatient imaging, laboratory, therapy, pharmacy, Kaiser primary and specialty physician offices, urgent care and observation service, medical IT facilities, administrative space, and public use space. In 2010, Kaiser received CON approval to include an outpatient surgery center with two ORs. In that CON application, Kaiser stated that new ambulatory surgical center ("ASC") would also include shell space for one additional OR.

While there are minor procedure rooms in other areas of the medical office building (which is typical in Kaiser medical offices), they are not part of the ambulatory surgery component of the building.

Kaiser Permanente's South Baltimore County Medical Center ("SBCMC") includes the following functional areas to ensure each patient has been properly evaluated prior to the surgical procedure, has their surgery safely completed by the surgeon, and receives the appropriate level of post-surgical care.

- Reception/Lounge: Patient check in and family waiting area

- Preoperative Area: Preparation for surgery, interviews with RN, Surgeon and Anesthesiologist administration of preoperative medications. The ASC will include 6 Pre-Op bays.

- Operating Rooms: standardized, increased room size for ease of scheduling, equipped with booms for video-endoscopy, pass-through capability for supplies from sterile core, in-room electronic medical record, imaging availability, supplies and drug storage

- Postoperative Area: postoperative area for recovery and observation until stable for discharge. The ASC will include three PACU bays, four stage II bays (for when patients have recovered from anesthesia) and one private stage II room.

- Central Sterile Processing: decontamination and sterilization of instruments

- Equipment Storage: for highly specialized medical equipment in the ever-advancing realm of outpatient surgery

- Staff Lounge/Locker Rooms: Dedicated area for staff to take breaks and change into scrubs

Daily operational responsibilities will be assumed by both a Nursing and Medical Director.

SBCMC is staffed by licensed and credentialed health care professionals including anesthesiologists, surgeons, CRNAs, RNs and surgical technologists. The staff follow evidence-based practice standards and those of their respective professional associations.

Like the ASCs that Kaiser operates in Kensington, Greenbelt, and Germantown, Maryland,), SBCMC primarily serves Kaiser members. The circumstances in which Kaiser ever bills for ambulatory surgical services are narrow and limited, and generate de minimus revenue (all of which are reimbursed to Kaiser – none accrue to the center). Occasionally, Kaiser members have dual coverage through another health benefits carrier, through an automobile insurance policy, or through Workers' Compensation. In those limited circumstances, Kaiser may bill the other carrier for the services it provides to the member. However, it must be remembered that these patients are still Kaiser members. Kaiser simply receives some payment because these patients have dual coverage.

In addition, some patients are covered under a self-funded employer plan for which Kaiser has contracted to provide its network of facilities and health care practitioners. While the care for members in self-funded groups is paid for by the self-

funded plan sponsor based on services provided, these members are treated in all other respects just like other members and for other purposes of Kaiser's tax exempt status are deemed to be members.

This application is to fit out the shell space for the third OR. Volumes at SBCMC have steadily increased, and SBCMC is operating well above what the MHCC considers to be optimal utilization.

9. Current Capacity and Proposed Changes:

Service	Unit Description	Currently Licensed/ Certified	Units to be Added or Reduced	Total Units if Project is Approved
ICF-MR	Beds	___/___		
ICF-C/D	Beds	___/___		
Residential Treatment	Beds	___/___		
Ambulatory Surgery	Operating Rooms	2	1	3
	Procedure Rooms	0	0	0
Home Health Agency	Counties	___/___		
Hospice Program	Counties	___/___		
Other (Specify)				
TOTAL		2	1	3

10. Identify any community based services that are or will be offered at the facility and explain how each one will be affected by the project.

11. **REQUIRED APPROVALS AND SITE CONTROL**

A. Site size: 9.4 acres

B. Have all necessary State and local land use and environmental approvals, including zoning and site plan, for the project as proposed been obtained? YES ✓ NO _____ (If NO, describe below the current status and timetable for receiving each of the necessary approvals.)

C. Form of Site Control (Respond to the one that applies. If more than one, explain.):

(1) Owned by: Kaiser Foundation Health Plan of the Mid-Atlantic States

(2) Options to purchase held by: _____
Please provide a copy of the purchase option as an attachment.

(3) Land Lease held by: _____
Please provide a copy of the land lease as an attachment.

(4) Option to lease held by: _____

Please provide a copy of the option to lease as an attachment.

(5) Other: _____
Explain and provide legal documents as an attachment.

12. PROJECT SCHEDULE
(INSTRUCTION: IN COMPLETING THE APPLICABLE OF ITEMS 10, 11 or 12, PLEASE CONSULT THE PERFORMANCE REQUIREMENT TARGET DATES SET FORTH IN COMMISSION REGULATIONS, COMAR 10.24.01.12)

For new construction or renovation projects.
Project Implementation Target Dates

A. Obligation of Capital Expenditure ____1____ months from approval date.
B. Beginning Construction _____1_____ months from capital obligation.
C. Pre-Licensure/First Use _____5_____ months from capital obligation.
D. Full Utilization _____12_____ months from first use.

For projects not involving construction or renovations.
Project Implementation Target Dates

A. Obligation or expenditure of 51% of Capital Expenditure _____ months from CON approval date.
B. Pre-Licensure/First Use _____ months from capital obligation.
C. Full Utilization _____ months from first use.

For projects not involving capital expenditures.
Project Implementation Target Dates

A. Obligation or expenditure of 51% Project Budget _____ months from CON approval date.
B. Pre-Licensure/First Use _____ months from CON approval.
C. Full Utilization _____ months from first use.

13. PROJECT DRAWINGS

Projects involving new construction and/or renovations should include scalable schematic drawings of the facility at least a 1/16" scale. Drawings should be completely legible and include dates.

These drawings should include the following before (existing) and after (proposed), as applicable:

A. Floor plans for each floor affected with all rooms labeled by purpose or function, number of beds, location of bath rooms, nursing stations, and any proposed space for future expansion to be constructed, but not finished at the completion of the project, labeled as "shell space".

B. For projects involving new construction and/or site work a Plot Plan, showing the

"footprint" and location of the facility before and after the project.

C. Specify dimensions and square footage of patient rooms.

14. FEATURES OF PROJECT CONSTRUCTION

A. If the project involves new construction or renovation, complete **Tables C and D of the Hospital CON Application Package**

B. Discuss the availability and adequacy of utilities (water, electricity, sewage, natural gas, etc.) for the proposed project and identify the provider of each utility. Specify the steps that will be necessary to obtain utilities.

All utilities are available on site.

PART II - PROJECT BUDGET

Complete Table E of the Hospital CON Application Package

Note: Applicant should include a list of all assumptions and specify what is included in each budget line, as well as the source of cost estimates and the manner in which all cost estimates are derived. Explain how the budgeted amount for contingencies was determined and why the amount budgeted is adequate for the project given the nature of the project and the current stage of design (i.e., schematic, working drawings, etc.).

PART III - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND RELEASE OF INFORMATION, AND SIGNATURE

1. List names and addresses of all owners and individuals responsible for the proposed project and its implementation.

   Michael Rogers, Executive Director, Strategic Planning, 2101 E. Jefferson St., Rockville, MD 20852

2. Are the applicant, owners, or the responsible persons listed in response to Part 1, questions 2, 3, 4, 7, and 9 above now involved, or have they ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of these facilities, including facility name, address, and dates of involvement.

   MedStar Health, Corporate Office 5565 Sterrett Place, Columbia, MD 21044; 2003 - 2009

3. Has the Maryland license or certification of the applicant facility, or any of the facilities listed in response to Question 2, above, been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant, owners or individuals responsible for implementation of the Project were not involved with the facility at the time a suspension, revocation, or disciplinary action took place, indicate in the explanation.

   NO

4. Other than the licensure or certification actions described in the response to Question 3, above, has any facility with which any applicant is involved, or has any facility with which any applicant has in the past been involved (listed in response to Question 2, above) received inquiries in last from 10 years from any federal or state authority, the Joint Commission, or other regulatory body regarding possible non-compliance with any state, federal, or Joint Commission requirements for the provision of, the quality of, or the payment for health care services that have resulted in actions leading to the possibility of penalties, admission bans, probationary status, or other sanctions at the applicant facility or at any facility listed in response to Question 2? If yes, provide for each such instance, copies of any settlement reached, proposed findings or final findings of non-compliance and related documentation including reports of non-compliance, responses of the facility, and any final disposition or conclusions reached by the applicable authority.

   NO

5. Have the applicant, owners or responsible individuals listed in response to Part 1, questions 2, 3, 4, 7, and 9, above, ever pled guilty to or been convicted of a criminal offense in any way connected with the ownership, development or management of the applicant facility or any of the health care facilities listed in response to Question 2, above? If yes, provide a written explanation of the circumstances, including as applicable the court, the date(s) of conviction(s), diversionary disposition(s) of any type, or guilty plea(s).

   NO

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or Board-designated official of the proposed or existing facility.

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information and belief.

2/4/2016
Date

Signature of Owner or Board-designated Official
Executive Director, Strategic Planning
Position/Title
Michael C. Rogers
Printed Name

PART IV - CONSISTENCY WITH GENERAL REVIEW CRITERIA AT COMAR 10.24.01.08G(3):

INSTRUCTION: Each applicant must respond to all criteria included in COMAR 0.24.01.08G(3), listed below.

An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards and other review criteria.

If a particular standard or criteria is covered in the response to a previous standard or criteria, the applicant may cite the specific location of those discussions in order to avoid duplication. When doing so, the applicant should ensure that the previous material directly pertains to the requirement and to the directions included in this application form. Incomplete responses to any requirement will result in an information request from Commission Staff to ensure adequacy of the response, which will prolong the application's review period.

10.24.01.08G(3)(a). <u>The State Health Plan</u>.

Every applicant must address each applicable standard in the chapter of the State Health Plan for Facilities and Services[2]. Commission staff can help guide applicants to the chapter(s) that applies to a particular proposal.

Please provide a direct, concise response explaining the project's consistency with each standard. Some standards require specific documentation (e.g., policies, certifications) which should be included within the application as an exhibit.

COMAR 10.24.11. GENERAL SURGICAL SERVICES
<u>.05A. GENERAL STANDARDS.</u>

Standard .05(A)(1) – <u>Information Regarding Charges.</u>

Information regarding charges for surgical services shall be available to the public. A hospital or an ambulatory surgical facility shall provide to the public, upon inquiry or as required by applicable regulations or law, information concerning charges for the full range of surgical services provided.

Applicant Response:

SBCMC provides to the public information on the range and types of services provided. However, as Kaiser is an HMO, serving primarily Kaiser members, there are no charges to most patients, other than HMO co-payments (which are typically fixed fees) and deductibles, as the cost of their care (including surgery) is covered by members' health plan premiums. The expenses at SBCMC will be covered completely by KFHP and will be funded from Kaiser's health plan revenue. Unlike non-HMO facilities SBCMC

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[2] [1] Copies of all applicable State Health Plan chapters are available from the Commission and are available on the Commission's web site here:http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_shp/hcfs_shp

will not directly bill members or insurance companies for services rendered. Any bills for services would come from Kaiser and not SBCMC itself, and Kaiser would collect any revenues from SBCMC services. Kaiser Kensington also does not bill Kaiser for services rendered. Rather, the expenses of operating Kaiser Kensington are fully funded by Kaiser.

Standard .05(A)(2) – Charity Care Policy.

(a) Each hospital and ambulatory surgical facility shall have a written policy for the provision of charity care that ensures access to services regardless of an individual's ability to pay and shall provide ambulatory surgical services on a charitable basis to qualified indigent persons consistent with this policy. The policy shall have the following provisions:

(i) Determination of Eligibility for Charity Care. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the facility shall make a determination of probable eligibility.

(ii) Notice of Charity Care Policy. Public notice and information regarding the facility's charity care policy shall be disseminated, on an annual basis, through methods designed to best reach the facility's service area population and in a format understandable by the service area population. Notices regarding the surgical facility's charity care policy shall be posted in the registration area and business office of the facility. Prior to a patient's arrival for surgery, facilities should address any financial concerns of patients, and individual notice regarding the facility's charity care policy shall be provided.

(iii) Criteria for Eligibility. Hospitals shall comply with applicable State statutes and HSCRC regulations regarding financial assistance policies and charity care eligibility. ASCs, at a minimum, must include the following eligibility criteria in charity care policies. Persons with family income below 100 percent of the current federal poverty guideline who have no health insurance coverage and are not eligible for any public program providing coverage for medical expenses shall be eligible for services free of charge. At a minimum, persons with family income above 100 percent of the federal poverty guideline but below 200 percent of the federal poverty guideline shall be eligible for services at a discounted charge, based on a sliding scale of discounts for family income bands. A health maintenance organization, acting as both the insurer and provider of health care services for members, shall have a financial assistance policy for its members that is

consistent with the minimum eligibility criteria for charity care required of ASCs described in these regulations.

(b) A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospitals, as reported in the most recent Health Service Cost Review Commission Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

(c) A proposal to establish or expand an ASC for which third party reimbursement is available, shall commit to provide charitable surgical services to indigent patients that are equivalent to at least the average amount of charity care provided by ASCs in the most recent year reported, measured as a percentage of total operating expenses. The applicant shall demonstrate that:

(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and

(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.

(iii) If an existing ASC has not met the expected level of charity care for the two most recent years reported to MHCC, the applicant shall demonstrate that the historic level of charity care was appropriate to the needs of the service area population.

(d) A health maintenance organization, acting as both the insurer and provider of health care services for members, if applying for a Certificate of Need for a surgical facility project, shall commit to provide charitable services to indigent patients. Charitable services may be surgical or nonsurgical and may include charitable programs that subsidize health plan coverage. At a minimum, the amount of charitable services provided as a percentage of total operating expenses for the health maintenance organization will be equivalent to the average amount of charity care provided statewide by ASCs, measured as a percentage of total ASC expenses, in the most recent year reported. The applicant shall demonstrate that:

(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and

(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.

(iii) If the health maintenance organization's track record is not consistent with the expected level for the population in the proposed service

area, the applicant shall demonstrate that the historic level of charity care was appropriate to the needs of the population in the proposed service area.

Applicant Response:

Kaiser Foundation Health Plan of the Mid-Atlantic States Inc.(KFHP) is a non-profit health plan focusing on pre-paid comprehensive health care coverage. It has an exclusive single contract with the Permanente Medical Group to provide or arrange for medical care services to Kaiser Permanente (KP) members, and KP Ambulatory Service Center(ASC) will be staffed exclusively by physicians from this medical group. KP's medical offices exist primarily to serve KP members and is required to meet regulatory access requirements for our members.

KP provides charitable care and coverage as part of its non-profit mission to improve health in the communities we serve. KP's charitable health programs differ from those of freestanding ASCs in that its programs focus on providing financial assistance to reduce barriers to care and coverage and care programs, rather than to secure a particular or limited medical services. KP works with community organizations and local governments to do outreach and enroll low income vulnerable individuals, families and children in our charitable health programs providing health plan care and coverage to uninsured populations that have no access to any other public or private care and coverage available. Individuals receiving charitable care from a KP ASC would primarily be existing participants in one of our charitable health programs, or members in need of assistance with co-payments and cost shares, rather than non-members applying at a KP ASC for financial assistance with surgical procedures.

KP's charitable health programs include the Charitable Health Access Program (CHAP), the Medical Care for Children Partnership (MCCP) Programs and the Medical Financial Assistance (MFA) Program which provides a financial award to offset copays and cost-shares to remove the financial barrier to care for the indigent (including members and non-members).

Charitable Health Access Program (CHAP)

KP collaborates with local governments and community based not-for-profit organizations to provide health care and coverage for uninsured families in need. CHAP helps those who do not qualify for any public or private care and coverage plans either commercially or through the ACA and are below 300% FPL. CHAP members receive a 100% subsidized premium and an MFA Award to help reduce the copays and cost-shares of the off-exchange Gold Medal Plan. The program offers up to 24 months of comprehensive coverage to qualified families. Once enrolled, members have access to primary, specialty, and preventive care, in-patient care, health education classes and all services provided within the KP integrated delivery system. After 24 months, recertification may be an option to remain in the program. KP enrolls members through community partners in Anne Arundel County, Baltimore City, Baltimore County, Frederick County, Howard County, Montgomery County and Prince George's County in Maryland. In 2014, Kaiser invested $10,942,434 in CHAP.

Medical Care for Children Partnership (MCCP)

KP partners with local governments, hospitals and/or nonprofit community groups who help us identify uninsured children who are ineligible for public or private health care programs and are below 300% FPL. Once enrolled in the program, children receive free primary care and all services available within the KP integrated delivery system. Over 3,700 children in the Mid-Atlantic Region were able to rely upon Kaiser Permanente as their medical home in 2015, giving our communities' most vulnerable members access to quality medical care. In 2014, Kaiser spent $4,937,943 in charitable care expenditures for this program in Maryland. Kaiser currently participates in partnerships in Montgomery County and Prince George's County in Maryland.

Medical Financial Assistance

The Medical Financial Assistance (MFA) Program is an income eligibility based financial assistance program to provide a defined amount of financial assistance to be used for health care services within Kaiser medical offices. Patients who cannot afford out-of-pocket costs of health care services may apply to this financial assistance program for free or reduced medical care services at Kaiser clinics, based on financial eligibility criteria. The MFA Program is open to Kaiser members who need assistance with co-payments for services, as well as to non-members seeking care from Kaiser medical offices. Copies of Kaiser's MFA policies are attached as Exhibit 2. Kaiser posts information about its MFA Program on its website, kp.org. A copy of the web site information brochure is attached as Exhibit 3. An application for MFA also appears on our web site. In addition, Kaiser displays posters and brochures in its medical offices regarding the availability of the MFA Program. Determination of probable eligibility is made within two business days.

Charity Care vs. Operating Expenses

In 2014, the total operating expenses for Kaiser Permanente Mid-Atlantic Region were $2,627,612,000. As outlined above, two of Kaiser's charitable programs (CHAP and MCCP) totaled $15,880,377 in 2014. This represents 0.6% of total operating expenses, exceeding the required threshold of 0.46% set by MHCC.

Standard .05(A)(3) – <u>Quality of Care.</u>

A facility providing surgical services shall provide high quality care.

(a) An existing hospital or ambulatory surgical facility shall document that it is licensed, in good standing, by the Maryland Department of Health and Mental Hygiene.

(b) A hospital shall document that it is accredited by the Joint Commission.

(c) An existing ambulatory surgical facility shall document that it is:

(i) **In compliance with the conditions of participation of the Medicare and Medicaid programs; and**

(ii) **Accredited by the Joint Commission, the Accreditation Association for Ambulatory Health Care, the American Association for Accreditation of Ambulatory Surgery Facilities, or another accreditation agency recognized by the Centers for Medicare and Medicaid as acceptable for obtaining Medicare certification.**

(d) **A person proposing the development of an ambulatory surgical facility shall demonstrate that the proposed facility will:**

(i) **Meet or exceed the minimum requirements for licensure in Maryland in the areas of administration, personnel, surgical services provision, anesthesia services provision, emergency services, hospitalization, pharmaceutical services, laboratory and radiologic services, medical records, and physical environment.**

(ii) **Obtain accreditation by the Joint Commission, the Accreditation Association for Ambulatory Health Care, or the American Association for Accreditation of Ambulatory Surgery Facilities within two years of initiating service at the facility or voluntarily suspend operation of the facility.**

Applicant Response:

SBCMC is in compliance with the conditions of participation of the Medicare/Medicaid programs. SBCMC is accredited by the Accreditation Association for Ambulatory Health Care, Inc. Exhibit 4 includes evidence of compliance.

Standard .05A(4) – <u>Transfer Agreements.</u>

(a) **Each ASC and hospital shall have written transfer and referral agreements with hospitals capable of managing cases that exceed the capabilities of the ASC or hospital.**

(b) **Written transfer agreements between hospitals shall comply with the Department of Health and Mental Hygiene regulations implementing the requirements of Health-General Article §19-308.2.**

(c) Each ASC shall have procedures for emergency transfer to a hospital that meet or exceed the minimum requirements in COMAR 10.05.05.09.

Applicant Response:

SBCMC has a transfer agreement with St. Agnes Hospital. Exhibit 5 includes a copy of the agreement.

COMAR 10.24.11. GENERAL SURGICAL SERVICES
.05B. Project Review Standards.

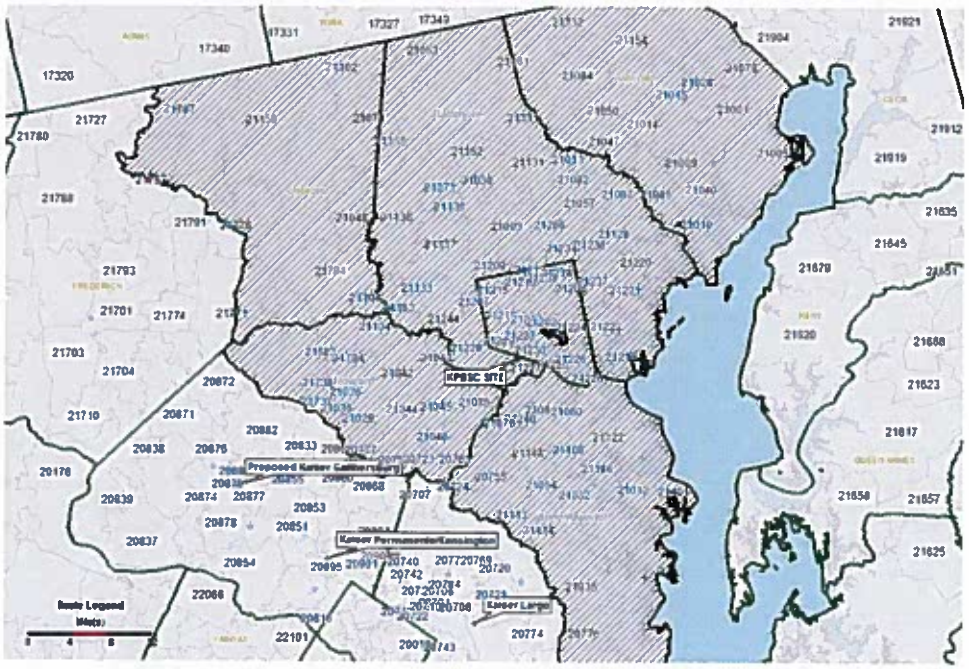
Standard .05B(1) – Service Area.

An applicant proposing to establish a new hospital providing surgical services or a new ambulatory surgical facility shall identify its projected service area. An applicant proposing to expand the number of operating rooms at an existing hospital or ambulatory surgical facility shall document its existing service area, based on the origin of patients served.

Applicant Response:

SBCMC's service area includes Baltimore City and Anne Arundel, Baltimore, Carroll, Harford, and Howard Counties. The service area is depicted below.

Figure 1
Service Area for SBCMC



Standard .05B(2) – Need- Minimum Utilization for Establishment of a New or Replacement Facility.

An applicant proposing to establish or replace a hospital or ambulatory surgical facility shall demonstrate the need for the number of operating rooms proposed for

the facility. This need demonstration shall utilize the operating room capacity assumptions and other guidance included in Regulation .06 of this Chapter. This needs assessment shall demonstrate that each proposed operating room is likely to be utilized at optimal capacity or higher levels within three years of the initiation of surgical services at the proposed facility.

(a) An applicant proposing the establishment or replacement of a hospital shall submit a needs assessment that includes the following:

(i) Historic trends in the use of surgical facilities for inpatient and outpatient surgical procedures by the new or replacement hospital's likely service area population;

(ii) The operating room time required for surgical cases projected at the proposed new or replacement hospital by surgical specialty or operating room category; and

(iii) In the case of a replacement hospital project involving relocation to a new site, an analysis of how surgical case volume is likely to change as a result of changes in the surgical practitioners using the hospital.

(b) An applicant proposing the establishment of a new ambulatory surgical facility shall submit a needs assessment that includes the following:

(i) Historic trends in the use of surgical facilities for outpatient surgical procedures by the proposed facility's likely service area population;

(ii) The operating room time required for surgical cases projected at the proposed facility by surgical specialty or, if approved by Commission staff, another set of categories; and

(iii) Documentation of the current surgical caseload of each physician likely to perform surgery at the proposed facility.

Applicant Response:

Inapplicable.

Standard .05B(3) – <u>Need - Minimum Utilization for Expansion of An Existing Facility.</u>

An applicant proposing to expand the number of operating rooms at an existing hospital or ambulatory surgical facility shall:

(a) Demonstrate the need for each proposed additional operating room, utilizing the operating room capacity assumptions and other guidance included at Regulation .06 of this Chapter;

(b) Demonstrate that its existing operating rooms were utilized at optimal capacity in the most recent 12-month period for which data has been reported to the Health Services Cost Review Commission or to the Maryland Health Care Commission; and

(c) Provide a needs assessment demonstrating that each proposed operating room is likely to be utilized at optimal capacity or higher levels within three years of the completion of the additional operating room capacity. The needs assessment shall include the following:

(i) Historic trends in the use of surgical facilities at the existing facility;

(ii) Operating room time required for surgical cases historically provided at the facility by surgical specialty or operating room category; and

(iii) Projected cases to be performed in each proposed additional operating room.

Applicant Response:

SBCMC opened in late 2012. Growth in volume has been high since it opened, and SBCMC needs the third OR today. As Table 5 shows, SBCMC needed 2.98 ORs in 2015. SBCMC has accommodated the excessive volumes by operating longer hours than the MHCC (and KP) believes are optimal. SBCMC would be applying for more ORs, but it would require considerably more time to develop, and SBCMC needs to add at least one OR as quickly as possible to reduce the current volume pressure. Projections beyond 2015 are based on projections of growth in future KP Baltimore Region subscribers.

Table 5
Surgical Cases, Minutes, and OR Need
SBCMC
2013 - 2018

	CY	Cases	Case Minutes	TAT @ 25 Min/Case	Total Min	Capacity/ OR	Needed ORs	% Change in Cases
Actual	2013	1,637	120,240	40,925	161,165	97,920	1.65	
Actual	2014	2,237	155,674	55,925	211,599	97,920	2.16	36.7%
Actual	2015	2,360	233,034	59,000	292,034	97,920	2.98	5.5%
Projected	2016	2,791	275,533	69,775	345,308	97,920	3.53	18.3%
Projected	2017	3,092	305,250	77,300	382,550	97,920	3.91	10.8%
Projected	2018	3,640	359,373	91,000	450,373	97,920	4.60	17.7%

Table 6 shows the number of cases at SBCMC, the number of Baltimore region KP subscribers, and the assumptions of the number of cases per 100 subscribers. It is clear from the previous table that SBCMC can justify the third OR based on current experience and volumes.

Table 6
SBCMC Surgical Cases, KP Baltimore Region Subscribers
2014 - 2018

	CY	Cases	Annual % Change	Subscribers	Annual % Change	Cases/100 Subscribers
Actual	2014	2,237	36.7%	67,583	N/A	3.31
Actual	2015	2,360	5.5%	85,183	26.0%	2.77
Projected	2016	2,791	18.3%	103,183	21.1%	2.70
Projected	2017	3,092	10.8%	117,233	13.6%	2.64
Projected	2018	3,640	17.7%	139,083	18.6%	2.62

Standard .05B(4) – <u>Design Requirements.</u>

Floor plans submitted by an applicant must be consistent with the current FGI Guidelines.

(a) A hospital shall meet the requirements in Section 2.2 of the FGI Guidelines.

(b) An ASC shall meet the requirements in Section 3.7 of the FGI Guidelines.

(c) Design features of a hospital or ASC that are at variance with the current FGI Guidelines shall be justified. The Commission may consider the opinion of staff at the Facility Guidelines Institute, which publishes the FGI Guidelines, to help determine whether the proposed variance is acceptable.

Applicant Response:

The new OR will be designed in compliance the 2014 FGI Guidelines Section 3.7. Please see Exhibit 6 for a letter from Mark Nicasio of HDR Architecture, Inc., Project Manager, the architect for this project, confirming the proposed facility's compliance with Section 3.7 of the FGI Guidelines.

Standard .05B(5) – <u>Support Services.</u>

Each applicant shall agree to provide as needed, either directly or through contractual agreements, laboratory, radiology, and pathology services.

Applicant Response:

Laboratory and radiology services are provided by Kaiser on site, as there are imaging and laboratory services located elsewhere in the building. Pathology services is also provided by Kaiser. Kaiser Mid-Atlantic operates a regionally centralized pathology service, located in Rockville.

Standard .05B(6) – Patient Safety.

The design of surgical facilities or changes to existing surgical facilities shall include features that enhance and improve patient safety. An applicant shall:

(a) Document the manner in which the planning of the project took patient safety into account; and

(b) Provide an analysis of patient safety features included in the design of proposed new, replacement, or renovated surgical facilities.

Applicant Response:

Patient safety is a key consideration in this project. The increased number of ORs will allow SBCMC to minimize the number of procedures performed in the late afternoons and evenings, times of day when industry studies have documented an increase in the incidence of medical errors. The new design of the OR will also address current patient safety standards.

The new OR room will be designed similarly to the existing ORs, which will minimize training requirements and allow staff to move from one room to another with minimal chance of confusion, thus improving patient safety.

Architectural features to promote patient safety in the OR are consistent with FGI *Guidelines for Design and Construction of Healthcare Facilities* and the Maryland Building Code. The proposed project will be built in strict accordance with those requirements. For example, finishes of the floors, walls, etc. are specified to maintain a sterile environment and minimize operative and post-operative infection risk. Similarly, mechanical filtration is designed to maintain optimum levels of air quality. SBCMC maintains infection control and risk assessment programs that will be incorporated throughout the design and construction processes.

User input is being actively included in the design process through review of plans and input on equipment and design features of the ORs. In addition to the code requirements described above, specific consideration is being given to the lighting in each room to identify any opportunities to minimize staff and surgeon fatigue from that source while still maintaining the illumination levels necessary to conduct the procedures.

As part of its commitment to high quality of care, Kaiser Permanente has made a significant investment in developing its secure Electronic Health Record ("EHR") system, KP HealthConnect™, to support the delivery of care to its members and to enhance communications among the medical professionals who serve them. This EHR system allows Kaiser physicians to access a patient's electronic medical record at any Kaiser center where the patient receives care. The system includes physician order entry for laboratory and radiology tests as well as electronic prescribing capability connected with Kaiser pharmacy systems. This system allows physicians to send diagnostic test orders and receive test results electronically, which creates efficiencies in obtaining rapid test results. Test results are displayed in the patient's EHR and are available to all Kaiser treating physicians with EHR access, preventing duplicate testing

and enhancing patient safety. The EHR system performs other patient-safety functions as well, such as automated clinical decision support for adverse drug event prevention, drug-allergy checking, alerts when preventive health screenings are due, and medication adherence monitoring. This system has increased efficiency, reduced errors, and improved patient care and patient safety.

Standard .05B(7) – Construction Costs.

The cost of constructing surgical facilities shall be reasonable and consistent with current industry cost experience.

(a) Hospital projects.

(i) The projected cost per square foot of a hospital construction or renovation project that includes surgical facilities shall be compared to the benchmark cost of good quality Class A hospital construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors.

(ii) If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the project shall not include:

1. The amount of the projected construction cost and associated capitalized construction cost that exceeds the Marshall Valuation Service® benchmark; and

2. Those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

(b) Ambulatory Surgical Facilities.

(i) The projected cost per square foot of an ambulatory surgical facility construction or renovation project shall be compared to the benchmark cost of good quality Class A construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service®

guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors.

(ii) If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost by 15% or more, then the applicant's project shall not be approved unless the applicant demonstrates the reasonableness of the construction costs. Additional independent construction cost estimates or information on the actual cost of recently constructed surgical facilities similar to the proposed facility may be provided to support an applicant's analysis of the reasonableness of the construction costs.

Applicant Response:

The following compares the project costs to the Marshall Valuation Service ("MVS") benchmark.

I. Marshall Valuation Service Calculation

Type		Outpatient Surgical Centers
Construction Quality/Class		Good A/B
Stories		2
Perimeter		404
Height of Ceiling		13.00
Square Feet		491
f.1	Average floor Area	491.00
A. Base Costs		
	Basic Structure	369.05
	Elimination of HVAC cost for adjustment	0
	HVAC Add-on for Mild Climate	0
	HVAC Add-on for Extreme Climate	0
Total Base Cost		$369.05
B. Additions		
	Elevator (If not in base)	$0.00
	Other	$0.00
Subtotal		$0.00
Total		$369.05
C. Multipliers		
Perimeter Multiplier		1.399984

Product	$516.66
Height Multiplier (plus/minus from 12')	1.023
Product	$528.55
Multi-story Multiplier (0.5%/story above 3)	1
Product	$528.55
D. Sprinklers	
Sprinkler Amount	-
Subtotal	$528.55
E. Update/Location Multipliers	
Update Multiplier	1.02
Product	$539.12
Location Multiplier	1.01
Product	$544.51
Final Square Foot Cost Benchmark	**$544.51**
Adjustment for Renovation Only	68.39%
Final Square Foot Cost Benchmark	**$372.37**

Please note the "Adjustment for Renovation Only." MVS does not have a benchmark for conversion of shell space in a medical office building ("MOB") into an ambulatory surgical center. The 68.39% "Adjustment for Renovation Only" derives from an approach that Kaiser's consultant (Andrew L. Solberg) did in the matter of Green Spring Station Surgical Center (Matter No. 15-03-2369). In that review, MHCC Staff asked Mr. Solberg to develop an approach for estimating an MVS benchmark for conversion of MOB space into an ASF. He did so, using the benchmarks for generic "Medical Office Buildings" and "Outpatient (Surgical) Centers."

He noted that in Section 87, page 8, MVS shows the "Budget Differential Costs by Department" (to which he refers to as Departmental Cost Differential Factors) for Hospitals (the only type of structure for which MVS supplies these factors). The area of the MOB in which this project will be located would be otherwise considered shell space (or, as MVS terms it on page 8, "Unassigned Space"). MVS estimates that the Departmental Cost Differential Factor for this kind of space is 0.5. Mr. Solberg assumed that the Departmental Cost Differentiation factor of 0.5 should be applied to the MVS benchmark for an MOB, to reflect the portion of the benchmark that reflected only the shell.

In order to calculate a benchmark for only the fitting out of shell space in a generic MOB into a surgery center, Mr. Solberg subtracted the half the benchmark for Medical Office Building from the benchmark for Outpatient (Surgical) Centers to obtain the benchmark for the fitting out of the generic MOB as a generic surgery center. He then calculated the percentage that this comprised of the full benchmark and calculated that this was 68.39%. He then applied that percentage to the project-specific calculated full benchmark for Outpatient (Surgical) Centers to obtain that project's benchmark for renovation only. He has done the same thing in this project.

II. Cost of Renovation

A. Base Calculations	**Actual**	**Per Sq. Foot**
New Construction	$366,006	$745.43
Fixed Equipment	In Building	
Site Preparation	$0	$0.00
Architectual Fees	$27,450	$55.91
Capitalized Construction Interest	$0	$0.00
Permits	$10,000	$20.37
Subtotal	$403,456	$821.70

III. Comparison

A. Adjusted Project Cost/Sq. Ft.	$821.70
B. Marshall & Swift Sq. Ft. Benchmark	$372.37

While the Project Costs are significantly higher than the benchmark, no patient charges will be affected, as patients are not charged for the services at KPBSC. Nor will Kaiser's premiums be raised, as they are based on keeping Kaiser competitive and larger overall operational costs. Kaiser will simply absorb all of the project costs.

Standard .05B(8) – <u>Financial Feasibility.</u>

A surgical facility project shall be financially feasible. Financial projections filed as part of an application that includes the establishment or expansion of surgical facilities and services shall be accompanied by a statement containing each assumption used to develop the projections.

(a) An applicant shall document that:

(i) Utilization projections are consistent with observed historic trends in use of the applicable service(s) by the likely service area population of the facility;

Applicant Response:

As shown above, SBCMC's current volumes document the need for the additional

OR.

(ii) Revenue estimates are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by the applicant facility or, if a new facility, the recent experience of similar facilities;

Applicant Response:

SBCMC will not charge patients for the services they obtain at SBCMC. Copayments and deductibles are charged by and accrued to Kaiser Foundation Health Plan of the Mid-Atlantic States (not SBCMC).

(iii) Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant facility, or, if a new facility, the recent experience of similar facilities; and

Applicant Response:

Staffing and expense projections are based on the utilization projections and current staffing levels and expense levels.

(iv) The facility will generate excess revenues over total expenses (including debt service expenses and plant and equipment depreciation), if utilization forecasts are achieved for the specific services affected by the project within five years of initiating operations.

Applicant Response:

As discussed previously, SBCMC will not charge patients for the services that they obtain at SBCMC. Copayments and deductibles are charged by and accrue to Kaiser Foundation Health Plan of the Mid-Atlantic States (not SBCMC). The expenses at SBCMC are entirely subsidized by Kaiser Foundation Health Plan of the Mid-Atlantic States.

(b) A project that does not generate excess revenues over total expenses even if utilization forecasts are achieved for the services affected by the project may be approved upon demonstration that overall facility financial performance will be positive and that the services will benefit the facility's primary service area population.

Applicant Response:

See the response to (a)(iv).

Standard .05B(9) – <u>Preference in Comparative Reviews.</u>

In the case of a comparative review of CON applications to establish an ambulatory surgical facility or provide surgical services, preference will be given to a project that commits to serve a larger proportion of charity care and Medicaid patients. Applicants' commitment to provide charity care will be evaluated based on their past record of providing such care and their proposed outreach strategies for meeting their projected levels of charity care.

Applicant Response:

Inapplicable.

10.24.01.08G(3)(b). Need.

The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

INSTRUCTIONS: Please discuss the need of the population served or to be served by the Project.

Responses should include a quantitative analysis that, at a minimum, describes the Project's expected service area, population size, characteristics, and projected growth. If the relevant chapter of the State Health Plan includes a need standard or need projection methodology, please reference/address it in your response. For applications proposing to address the need of special population groups, please specifically identify those populations that are underserved and describe how this Project will address their needs.

If the project involves modernization of an existing facility through renovation and/or expansion, provide a detailed explanation of why such modernization is needed by the service area population. Identify and discuss relevant building or life safety code issues, age of physical plant issues, or standard of care issues that support the need for the proposed modernization.

Please assure that all sources of information used in the need analysis are identified. List all assumptions made in the need analysis regarding demand for services, utilization rate(s), and the relevant population, and provide information supporting the validity of the assumptions.

Complete Tables 1 and/or 2 below, as applies.

Applicant Response:

Please see the response to Standard .05B(3) – Need - Minimum Utilization for Expansion of An Existing Facility.

[(INSTRUCTION: Complete Table 1 for the Entire Facility, including the proposed project, and Table 2 for the proposed project only using the space provided on the following pages. Only existing facility applicants should complete Table 1. All Applicants should complete Table 2. Please indicate on the Table if the reporting period is Calendar Year (CY) or Fiscal Year (FY)]

TABLE 1: STATISTICAL PROJECTIONS - ENTIRE FACILITY

	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20___	20___	20___	20___	20___
1. Admissions							
a. ICF-MR							
b. RTC-Residents							
Day Students							
c. ICF-C/D							
d. Other (Specify)							
e. TOTAL							
2. Patient Days							
a. ICF-MR							
b. RTC-Residents							
c. ICF-C/D							
d. Other (Specify)							
e. TOTAL							

Table 1 Cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20___	20___	20___	20___	20___
3. Average Length of Stay							
a. ICF-MR							
b. RTC-Residents							
c. ICF-C/D							
d. Other (Specify)							
e. TOTAL							
4. Occupancy Percentage*							
a. ICF-MR							
b. RTC-Residents							
c. ICF-C/D							
d. Other (Specify)							
e. TOTAL							
5. Number of Licensed Beds*							
a. ICF-MR							
b. RTC-Residents							
c. ICF-C/D							
d. Other (Specify)							
e. TOTAL							
6. Home Health Agencies							
a. SN Visits							
b. Home Health Aide							
c. Other Staff							
d.							
e. Total patients srvd.							

Table 1 Cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	2013	2014	2015	2016	2017	2018	
7. Hospice Programs							
a. SN visits							
b. Social work visits							
c. Other staff visits							
d.							
e. Total patients srvd.							
8. Ambulatory Surgical Facilities							
a. Number of operating rooms (ORs)	2	2	2	2	3	3	
• Total Procedures in ORs	3,442	5,702	7,288	8,582	9,508	11,193	
• Total Cases in ORs	1,637	2,237	2,360	2,791	3,092	3,640	
• Total Surgical Minutes in ORs**	120,240	155,674	233,034	275,533	305,250	359,373	
b. Number of Procedure Rooms (PRs)	N/A	N/A	N/A	N/A	N/A	N/A	
• Total Procedures in PRs	N/A	N/A	N/A	N/A	N/A	N/A	
• Total Cases in PRs	N/A	N/A	N/A	N/A	N/A	N/A	
• Total Minutes in PRs**	N/A	N/A	N/A	N/A	N/A	N/A	

*Number of beds and occupancy percentage should be reported on the basis of licensed beds.
**Do not include turnover time.

TABLE 2: STATISTICAL PROJECTIONS - PROPOSED PROJECT
(INSTRUCTION: All applicants should complete this table.)

	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	20__	20__	20__	20__
1. Admissions				
a. ICF-MR				
b. RTC-Residents				
Day Students				
c. ICF-C/D				
d. Other (Specify)				
e. TOTAL				
2. Patient Days				
a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D				
d. Other (Specify)				
e. TOTAL				
3. Average Length of Stay				
a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D				
d. Other (Specify)				
e. TOTAL				
4. Occupancy Percentage*				
a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D				
d. Other (Specify)				
e. TOTAL				

Table 2 Cont.	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	20__	20__	20__	20__
5. Number of Licensed Beds				
a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D				
d. Other (Specify)				
e. TOTAL				
6. Home Health Agencies				
a. SN Visits				
b. Home Health Aide				
c.				
d.				
e. Total patients served				
7. Hospice Programs				
a. SN Visits				
b. Social work visits				
c. Other staff visits				
d. Total patients served				
8. Ambulatory Surgical Facilities				
a. Number of operating rooms (ORs)				
• Total Procedures in ORs				
• Total Cases in ORs				
• Total Surgical Minutes in ORs**				
b. Number of Procedure Rooms (PRs)				
• Total Procedures in PRs				
• Total Cases in PRs				
• Total Minutes in PRs**				

*Do no include turnover time

10.24.01.08G(3)(c). Availability of More Cost-Effective Alternatives.

The Commission shall compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

INSTRUCTIONS: Please describe the planning process that was used to develop the proposed project. This should include a full explanation of the primary goals or objectives of the project or the problem(s) being addressed by the project. It should also identify the alternative approaches to achieving those goals or objectives or solving those problem(s) that were considered during the project planning process, including the alternative of the services being provided by existing facilities.

For all alternative approaches, provide information on the level of effectiveness in goal or objective achievement or problem resolution that each alternative would be likely to achieve and the costs of each alternative. The cost analysis should go beyond development cost to consider life cycle costs of project alternatives. This narrative should clearly convey the analytical findings and reasoning that supported the project choices made. It should demonstrate why the proposed project provides the most effective goal and objective achievement or the most effective solution to the identified problem(s) for the level of cost required to implement the project, when compared to the effectiveness and cost of alternatives including the alternative of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

Applicant Response:

SBCMC considered three alternatives:

1. Do nothing
2. Add more than one OR
3. Add one OR

As the response to Standard .05B(3) – Need - Minimum Utilization for Expansion of An Existing Facility demonstrates, SBCMC is currently operating well in excess of the MHCC's (and KP's) definition of optimal utilization. The goal of this project is to increase OR capacity and reduce the stress caused by over utilization.

Doing nothing would not achieve the goal of reducing the over-utilization of the two existing ORs. As OR volumes continue to increase, the two ORs will simply become more stressed, operating hours will have to increase, and subscriber satisfaction will be reduced.

The original CON that established SBCMC (Matter No. 10-03-2306) included shell space for one OR. Hence, adding one OR can be accomplished relatively quickly by fitting out the shell space. While SBCMC believes that it could justify adding more than one OR, there is not currently room to do so, and it would require relocating adjacent services, causing a domino effect of renovation and relocation. This would take substantially longer to accomplish than

simply fitting out the shell space. The sole criterion that was used to choose between adding one OR and adding more than one was timing. KP may well seek approval to add additional ORs in the future, but the need to reduce the current stress is immediate.

Consequently, KP chose the alternative to add one OR by fitting out the existing shell space.

10.24.01.08G(3)(d). Viability of the Proposal.

The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

INSTRUCTIONS: Please provide a complete description of the funding plan for the project, documenting the availability of equity, grant(s), or philanthropic sources of funds and demonstrating, to the extent possible, the ability of the applicant to obtain the debt financing proposed. Describe the alternative financing mechanisms considered in project planning and provide an explanation of why the proposed mix of funding sources was chosen.

- Complete Tables 3 and/or 4 below, as applicable. Attach additional pages as necessary detailing assumptions with respect to each revenue and expense line item.

- Complete Table L (Workforce) from the Hospital CON Application Table Package.

- Audited financial statements for the past two years should be provided by all applicant entities and parent companies to demonstrate the financial condition of the entities involved and the availability of the equity contribution. If audited financial statements are not available for the entity or individuals that will provide the equity contribution, submit documentation of the financial condition of the entities and/or individuals providing the funds and the availability of such funds. Acceptable documentation is a letter signed by an independent Certified Public Accountant. Such letter shall detail the financial information considered by the CPA in reaching the conclusion that adequate funds are available.

- If debt financing is required and/or grants or fund raising is proposed, detail the experience of the entities and/or individuals involved in obtaining such financing and grants and in raising funds for similar projects. If grant funding is proposed, identify the grant that has been or will be pursued and document the eligibility of the proposed project for the grant.

- Describe and document relevant community support for the proposed project.

- Identify the performance requirements applicable to the proposed project (see question 12, "Project Schedule") and explain how the applicant will be able to implement the project in compliance with those performance requirements. Explain the process for completing the project design, obtaining State and local land use, environmental, and design approvals, contracting and obligating the funds within the prescribed time frame. Describe the construction process or refer to a description elsewhere in the application that demonstrates that the project can be completed within the applicable time frame(s).

Applicant Response:

The most recent audited financial statements for Kaiser Foundation Health Plan of the Mid-Atlantic States are attached as Exhibit 7. These statements demonstrate that Kaiser has adequate funds to make the cash contribution listed in the Sources of Funds in the Project Budget.

SBCMC will not charge patients for the services that they obtain at SBCMC. Copayments and deductibles are charged by and accrue to Kaiser Foundation Health Plan of the Mid-Atlantic States (not SBCMC). Since Kaiser facilities do not charge on a fee for service basis, there is no impact on charges.

There will be no debt for this project.

Because SBCMC will be increasing its capacity by 50% of its current licensed capacity (adding one OR to two existing ORs), SBCMC believes that the following Performance Requirement is applicable to this project:

> (d) A major change in bed capacity (greater than 40 beds or 25 percent of total licensed capacity), additions, replacements, modernization, relocation, or conversions to an existing inpatient health care facility that involves a capital expenditure between the threshold specified in Regulation .01B of this chapter and $5,000,000 has up to 18 months to obligate 51 percent of the approved capital expenditure, and up to 12 months after the effective date of a binding construction contract to complete the project;

As shown previously, SBCMC anticipates completing this project considerably sooner than that outlined in this performance requirement.

TABLE 3: <u>REVENUES AND EXPENSES - ENTIRE FACILITY</u> (including proposed project)

(INSTRUCTION: ALL EXISTING FACILITY APPLICANTS MUST SUBMIT AUDITED FINANCIAL STATEMENTS)

	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20___	20___	20___	20___	20___
1. Revenue							
a. Inpatient services							
b. Outpatient services							
c. Gross Patient Service Revenue							
d. Allowance for Bad Debt							
e. Contractual Allowance							
f. Charity Care							
g. Net Patient Services Revenue							
h. Other Operating Revenues (Specify)							
i. Net Operating Revenue							

Table 3 Cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle	2014	2015	2016	2017	2018	20___	20-___
2. Expenses							
a. Salaries, Wages, and Professional Fees, (including fringe benefits)	$6,451,667	$8,308,039	$9,442,552	$12,930,600	$13,313,516		
b. Contractual Services							
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation	$1,450,558	$1,429,391	$1,419,655	$1,413,332	$985,408		
f. Project Depreciation				$192,459	$192,459		
g. Current Amortization							
h. Project Amortization							
i. Supplies	$3,692,095	$4,381,583	$5,002,225	$7,719,717	$7,896,136		
j. Other Expenses (Specify)							
k. Total Operating Expenses	$11,594,320	$14,119,013	$15,864,432	$22,256,108	$22,387,519		
3. Income							
a. Income from Operation							
b. Non-Operating Income							
c. Subtotal							
d. Income Taxes							
e. Net Income (Loss)							

Table 3 Cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20___	20___	20___	20___	20___
4. Patient Mix: A. Percent of Total Revenue							
1. Medicare							
2. Medicaid							
3. Blue Cross							
4. Commercial Insurance							
5. Self-Pay							
6. Other (Specify)							
7. TOTAL	100%	100%	100%	100%	100%	100%	100%
B. Percent of Patient Days/Visits/Procedures (as applicable)							
1. Medicare							
2. Medicaid							
3. Blue Cross							
4. Commercial Insurance							
5. Self-Pay							
6. Other (Specify)							
7. TOTAL	100%	100%	100%	100%	100%	100%	100%

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

(INSTRUCTION: Each applicant should complete this table for the proposed project only)

	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	20__	20__	20__	20__
1. Revenues				
a. Inpatient Services				
b. Outpatient Services				
c. Gross Patient Services Revenue				
d. Allowance for Bad Debt				
e. Contractual Allowance				
f. Charity Care				
g. Net Patient Care Service Revenues				
h. Total Net Operating Revenue				
2. Expenses				
a. Salaries, Wages, and Professional Fees, (including fringe benefits)				
b. Contractual Services				
c. Interest on Current Debt				
d. Interest on Project Debt				
e. Current Depreciation				
f. Project Depreciation				
g. Current Amortization				
h. Project Amortization				
i. Supplies				
j. Other Expenses (Specify)				
k. Total Operating Expenses				

10.24.01.08G(3)(e). Compliance with Conditions of Previous Certificates of Need.

An applicant shall demonstrate compliance with all terms and conditions of each previous Certificate of Need granted to the applicant, and with all commitments made that earned preferences in obtaining each previous Certificate of Need, or provide the Commission with a written notice and explanation as to why the conditions or commitments were not met.

INSTRUCTIONS: List all of the Maryland Certificates of Need that have been issued to the project applicant, its parent, or its affiliates or subsidiaries over the prior 15 years, including their terms and conditions, and any changes to approved Certificates that needed to be obtained. Document that these projects were or are being implemented in compliance with all of their terms and conditions or explain why this was not the case.

Applicant Response:

In 2010, Kaiser received three CONs for the approval to establish three separate ASCs in Largo (Docket No. 09-16-2304), Gaithersburg (Docket No. 09-15-2303), and Baltimore (Docket No. 10-03-2306). The Baltimore CON was approved on June 17, 2010 with the following two conditions:

1. SBCMC must provide the Commission with documentation that it has obtained accreditation from the Joint Commission on Accreditation of Healthcare Organizations or the Accreditation Association for Ambulatory Health Care within 18 months of first use approval.

2. Before first use approval of SBCMC, Kaiser shall submit a transfer agreement that meets the requirements of the Department of Health and Mental Hygiene regulations implementing Health-General Article, §19-308.2, Annotated Code of Maryland.

(All three CONs had the same conditions attached to them.)

Kaiser met both conditions for all three projects. All three projects received Pre-Licensing Certification by the MHCC.

10.24.01.08G(3)(f). Impact on Existing Providers and the Health Care Delivery System.

An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

INSTRUCTIONS: Please provide an analysis of the impact of the proposed project. Please assure that all sources of information used in the impact analysis are identified and identify all the assumptions made in the impact analysis with respect to demand for services, payer mix, access to service and cost to the health care delivery system including relevant populations considered in the analysis, and changes in market share, with information that supports the validity of these assumptions. Provide an analysis of the following impacts:

a) On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project;

b) On the payer mix of all other existing health care providers that are likely to experience some impact on payer mix as a result of this project. If an applicant for a new nursing home claims no impact on payer mix, the applicant must identify the likely source of any expected increase in patients by payer.

c) On access to health care services for the service area population that will be served by the project. (State and support the assumptions used in this analysis of the impact on access);

d) On costs to the health care delivery system.

If the applicant is an existing facility or program, provide a summary description of the impact of the proposed project on the applicant's costs and charges, consistent with the information provided in the Project Budget, the projections of revenues and expenses, and the work force information.

Applicant Response:

This project will have no impact on other facilities, as it is intended to serve the volumes already experienced by SBCMC. It will have no impact on payer mix, as it is intended for Kaiser Permanente subscribers. This will increase access for Kaiser Permanente subscribers, enabling more scheduling flexibility for surgical cases. It will have no impact on costs to the health care system, as it has no impact on Kaiser Permanente premiums and is intended to serve subscribers already using SBCMC.

Exhibit 1

PROJECT DESCRIPTION

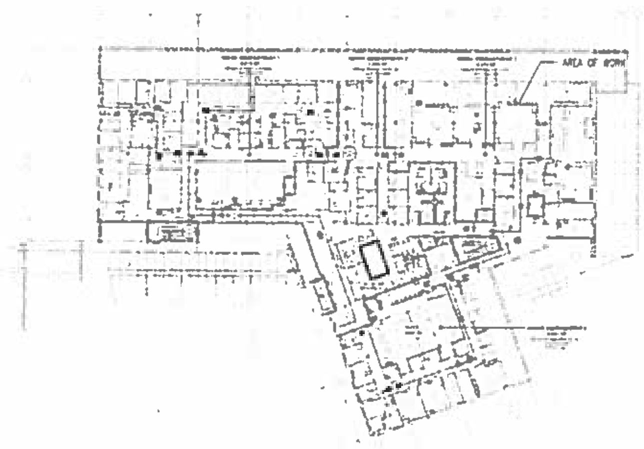
The existing Kaiser Permanente South Baltimore Medical Center currently has an Ambulatory Surgery Center (ASC) located on the second floor of the facility. The ASC has two active operating room and a shelled space for a third operating room (OR). The facility and supporting departments were planned to accommodate the third OR. The existing spaces have been validated and there is capacity to support additional case load created by new OR including ancillary departments such as Sterile Processing, Pre Operative and Recovery.
The work includes the interior fit-out of OR-03 477 SF (Room number 2B312) and the Scrub Alcove immediately outside of OR-03 17 SF (Room number 2B310F

BUILDING CODE SUMMARY

LIFE SAFETY SYSTEM REQUIREMENTS

EXIT REQUIREMENTS

FIRST FLOOR	3	3	200 FT	FT	99 FT	172 FT
SECOND FLOOR	3	3	200 FT	FT	94 FT	100 FT
THIRD FLOOR	3	3	200 FT	–	94 FT	100 FT
FOURTH FLOOR	2	2	200 FT	–	94 FT	100 FT
ROOF	1	1	–	–	–	–



PARTIAL SECOND FLOOR LIFE SAFETY PLAN

GENERAL NOTES:

A. NO CHANGE TO EXISTING SECOND FLOOR LIFE SAFETY

LIFE SAFETY AND EXITING LEGEND

SHEET INDEX:

ARCHITECTURAL
- G0.01 – SECOND FLOOR LIFE SAFETY AND INDEX OF DRAWINGS
- A2.01 – FLOOR PLANS – SECOND FLOOR SECTION EF
- A3.01 – INTERIOR ELEVATIONS

STRUCTURAL
- NO DRAWINGS

MECHANICAL
- M1.01 – FLOOR PLANS – SECOND FLOOR SECTION EF

PLUMBING
- P0.01 – FLOOR PLANS – SECOND FLOOR SECTION EF
- P2.01 – FLOOR PLANS – SECOND FLOOR SECTION EF

ELECTRICAL
- E1.01 – OR3 ELECTRICAL PARTIAL RISER & FLOOR PLANS

KEY PLAN

KAISER PERMANENTE.

HDR

TENANT IMPROVEMENTS

BALTIMORE HUB
1701 TWIN SPRINGS ROAD
BALTIMORE, MD 21227

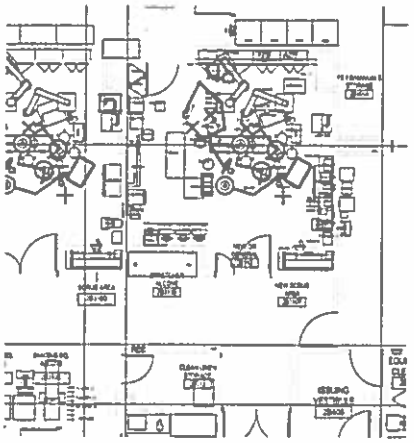
SOUTH BALTIMORE ASC EXPANSION

SECOND FLOOR LIFE SAFETY INDEX OF DRAWINGS

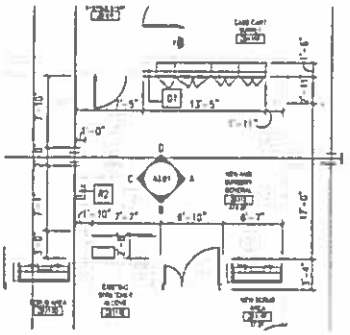
G0.01

GENERAL NOTES:

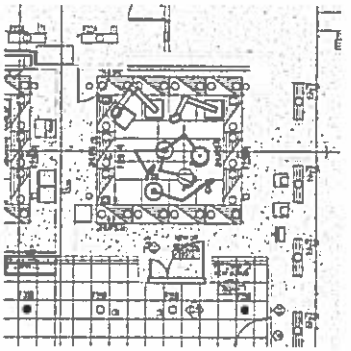
A. REFER TO ARCHITECTURAL NARRATIVE FOR ADDITIONAL INFORMATION
B. REFER TO NARRATIVE APPENDIX FOR COMPLETE EQUIPMENT LIST



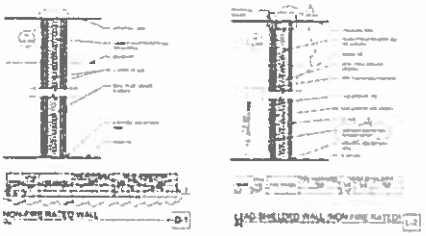
1 EQUIPMENT PLAN OR-03



2 FLOOR PLAN OR-03



3 REFLECTED CEILING PLAN OR-03



4 PARTITION TYPES

KEY PLAN

KAISER PERMANENTE

Kaiser Foundation Hospitals
National Facilities Services
1800 Harrison Street
Oakland, California 94612

HDR

TENANT IMPROVEMENTS

BALTIMORE MOB
1701 TWIN SPRINGS ROAD
BALTIMORE, MD 21227

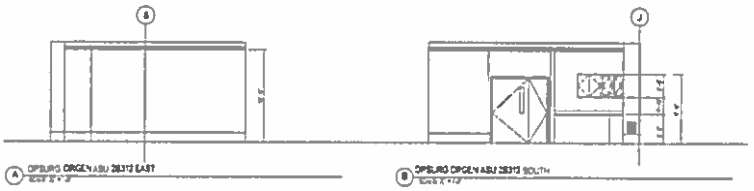
SOUTH BALTIMORE
ADC EXPANSION

PLANS
FLOOR PLANS
SECOND FLOOR SECTION 6F

A2.01

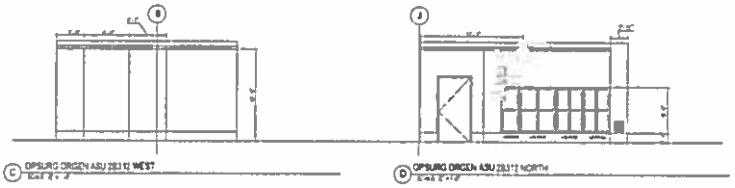
GENERAL NOTES:

A. REFER TO ARCHITECTURAL NARRATIVE FOR ADDITIONAL INFORMATION



A OPSURG ORGEN ASU 28312 EAST

B OPSURG ORGEN ASU 28312 SOUTH



C OPSURG ORGEN ASU 28312 WEST

D OPSURG ORGEN ASU 28312 NORTH

KAISER PERMANENTE

Kaiser Foundation Hospitals
National Facilities Services
1800 Harrison Street
Oakland, California 94612

HDR

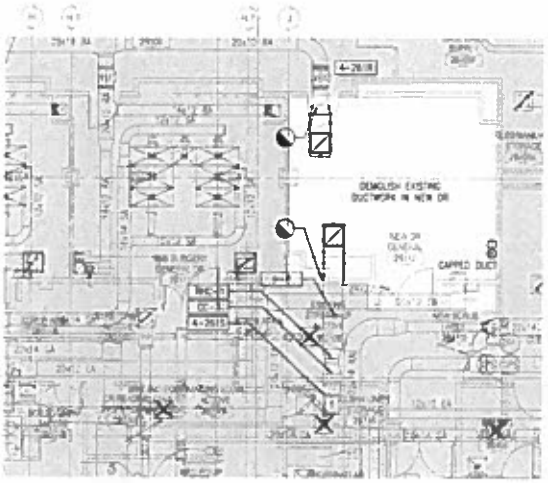
TENANT IMPROVEMENTS

BALTIMORE MOB
1701 TWIN SPRINGS ROAD
BALTIMORE, MD 21227

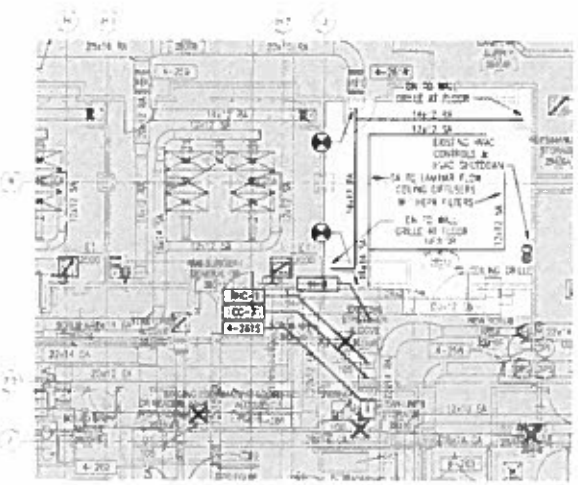
SOUTH BALTIMORE
ASC EXPANSION

INTERIOR
ELEVATIONS

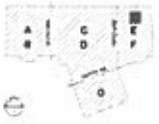
A3.01



1 HVAC DEMOLITION PARTIAL FLOOR PLAN - DR3



2 HVAC NEW WORK PARTIAL FLOOR PLAN - DR3



KEY PLAN

KAISER PERMANENTE

Kaiser Foundation Hospitals
National Facilities Services
1800 Harrison Street
Oakland, California 94612

HDR

VANDERWEIL

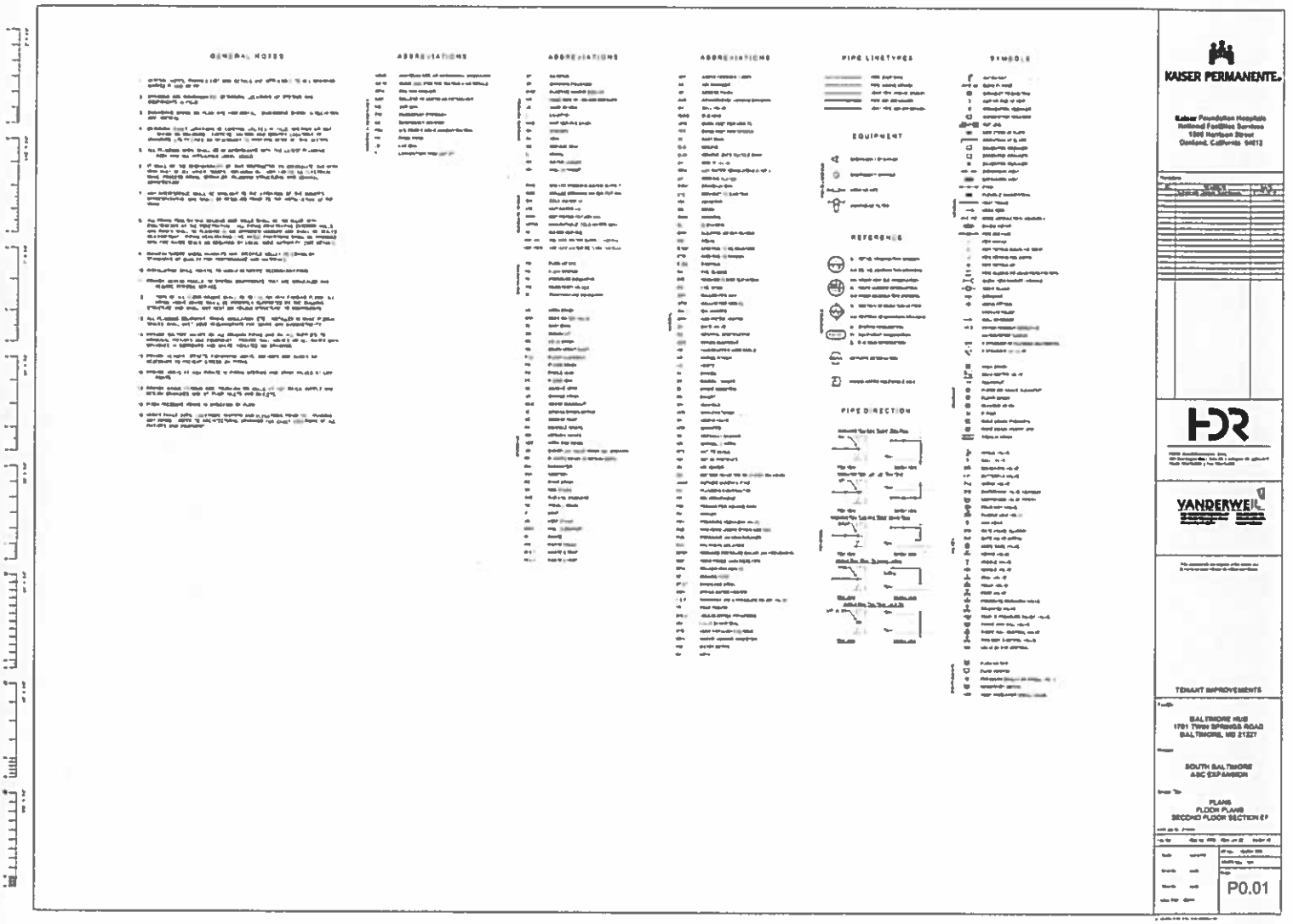
TENANT IMPROVEMENTS

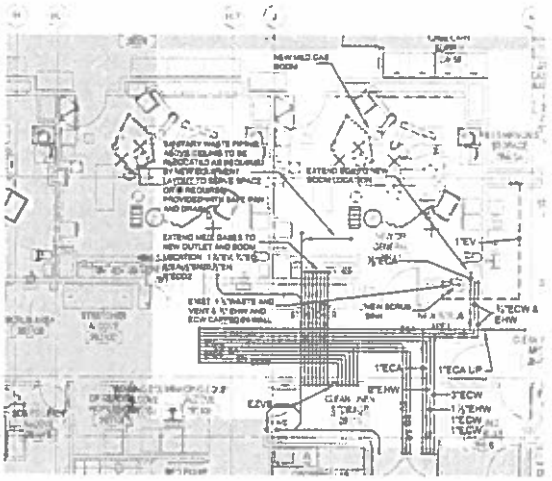
BALTIMORE HUB
1701 Pine Sprindle Road
BALTIMORE, MD 21227

SOUTH BALTIMORE
ASC EXPANSION

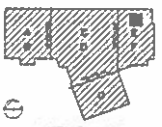
DR3 MECHANICAL
FLOOR PLANS
SECOND FLOOR SECTION D

M1.01


GENERAL NOTES
ABBREVIATIONS
ABBREVIATIONS
ABBREVIATIONS
PIPE LINETYPES
EQUIPMENT
REFERENCE
PIPE DIRECTION
SYMBOLS
KAISER PERMANENTE
Kaiser Foundation Hospitals
Regional Facilities Services
1800 Harrison Street
Oakland, California 94612
HDR
YANDERWEIL
TENANT IMPROVEMENTS
BALTIMORE MOB
1701 TWIN SPRINGS ROAD
BALTIMORE, MD 21227
SOUTH BALTIMORE
ASC EXPANSION
PLANS
FLOOR PLANS
SECOND FLOOR SECTION EP
P0.01



1 PLUMBING NEW WORK PARTIAL FLOOR PLAN - OR3



KEY PLAN

KAISER PERMANENTE.

Kaiser Foundation Hospitals
National Facilities Services
1800 Harrison Street
Oakland, California 94612

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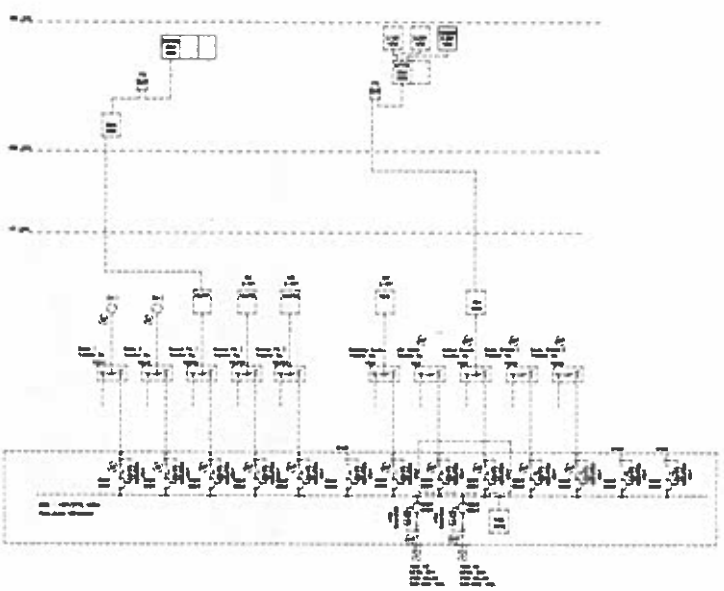
TENANT IMPROVEMENTS

BALTIMORE MOB
1701 TWIN SPRINGS ROAD
BALTIMORE, MD 21227

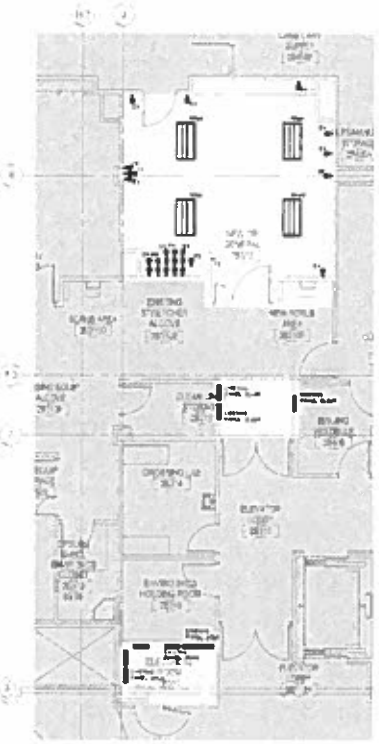
SOUTH BALTIMORE
ASC EXPANSION

PLANS
FLOOR PLANS
SECOND FLOOR SECTION E7

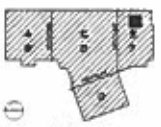
P2.01



1 PARTIAL EXISTING ELECTRICAL RISER



2 PARTIAL FLOOR PLAN - DR3 EXISTING CONDITION



KEY PLAN

KAISER PERMANENTE

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BALTIMORE, MD 21227

SOUTH BALTIMORE
ASC EXPANSION

DR3 ELECTRICAL PARTIAL
RISER & FLOOR PLANS

E1.01

Exhibit 2

Policy Title: Medical Financial Assistance	Policy Number: **NATL.CB.307**
Owner Department: **National Community Benefit**	Effective Date: **January 1, 2016**
Custodian: **Director, Medical Financial Assistance**	Page: 1 of 15

1.0 Policy Statement

Kaiser Foundation Hospitals (KFH) and Kaiser Foundation Health Plans (KFHP) are committed to providing programs that facilitate access to care for vulnerable populations. This commitment includes providing financial assistance to qualified low income uninsured and underinsured patients when the ability to pay for services is a barrier to accessing emergency and medically necessary care.

2.0 Purpose

This policy describes the requirements for qualifying for and receiving financial assistance for emergency and medically necessary services through the Medical Financial Assistance (MFA) program. The requirements are compliant with Section 501(r) of the United States Internal Revenue Code and applicable state regulations addressing eligible services, how to obtain access, program eligibility criteria, the structure of MFA awards, the basis for calculating award amounts, and the allowable actions in the event of nonpayment of medical bills.

3.0 Scope

This policy applies to employees who are employed by the following entities and their subsidiaries (collectively referred to as "KFH/HP"):

3.1 Kaiser Foundation Hospitals,

3.2 Kaiser Foundation Health Plan, Inc., and

3.3 KFH/HP's subsidiaries.

3.4 This policy applies to the Kaiser Foundation Hospitals listed in the attached ADDENDUM, *Section I, Kaiser Foundation Hospitals*, and incorporated herein by reference.

4.0 Definitions

Refer to Appendix A – Glossary of Policy Terms.

5.0 Provisions

KFH/HP maintains a means-tested MFA program to mitigate financial barriers to receiving emergency and medically necessary care for eligible patients regardless of a patient's age, disability, gender, race, religious affiliation, social or immigrant status, sexual orientation, national origin, and whether or not the patient has health coverage.

5.1 Services that are Eligible and Not Eligible under the MFA Policy. Unless otherwise noted in the attached ADDENDUM, *Section II, Additional Services Eligible and Not Eligible under the MFA Policy.*

5.1.1 Eligible Services. MFA may be applied to emergency and medically necessary health care services, pharmacy services and products, and medical supplies provided at KP facilities (e.g. hospitals, medical centers, and medical office buildings), at KFH/HP outpatient pharmacies, or by Kaiser Permanente (KP) providers. MFA may be applied to services and products as described below:

5.1.1.1 Medically Necessary Services. Care, treatment, or services ordered or provided by a KP provider that are needed for the prevention, evaluation, diagnosis or treatment of a medical condition and are not mainly for the convenience of the patient or medical care provider.

5.1.1.2 Prescriptions and Pharmacy Supplies. Prescriptions presented at a KFH/HP outpatient pharmacy and written by KP providers, non-KP Emergency Department providers, non-KP Urgent Care providers, and KP contracted providers.

5.1.1.2.1 Generic Medications. The preferred use of generic medications, whenever possible.

5.1.1.2.2 Brand Medications. Brand name medications when a KP provider prescribes the brand name medication and notes "Dispense as Written" (DAW), or there is no generic equivalent available.

5.1.1.2.3 Medicare Beneficiaries. Applied to Medicare beneficiaries for prescription drugs covered under Medicare Part D in the form of a pharmacy waiver.

5.1.1.3 Additional Eligible Services Available. Additional services that are eligible under the MFA policy are identified in the attached ADDENDUM, *Section II, Additional Services Eligible and Not Eligible under the MFA Policy.*

5.1.2 Non-Eligible Services. MFA may not be applied to:

5.1.2.1 Services that are Not Considered Emergent or Medically Necessary as Determined by a KP Provider. (1) Cosmetic surgery or services, (2) infertility treatments, (3) retail medical supplies, (4) surrogacy services, and (5) services related to third party liability, or workers' compensation cases.

5.1.2.2 Prescriptions and Pharmacy Supplies. Prescriptions and supplies not considered emergent or medically necessary include, but are not limited to, (1) over-the-counter drugs or supplies and (2) specifically excluded drugs (e.g., fertility, cosmetic, sexual dysfunction).

5.1.2.3 Prescriptions for Medicare Part D Enrollees Eligible for or Enrolled in Low Income Subsidy (LIS) Program. The remaining cost share for prescription drugs for Medicare Advantage Part D enrollees who are either eligible for or enrolled in the LIS program, in accordance with Centers for Medicare & Medicaid Services (CMS) guidelines.

5.1.2.4 Services Provided Outside of KP Facilities. The MFA policy applies only to services provided at KP facilities, by KP providers. Even upon referral from a KP provider, all other services are ineligible for MFA. Services provided at non-KP medical offices, urgent care facilities and emergency departments, as well as home health, hospice, recuperative care, and custodial care services, are excluded.

5.1.2.5 Health Plan Premiums. The MFA program does not help patients pay the expenses associated with health insurance premiums.

5.1.2.6 Additional Non-Eligible Services. Additional services that are not eligible under the MFA policy are identified in the attached ADDENDUM, *Section II, Additional Services Eligible and Not Eligible under the MFA Policy.*

5.2 Providers. MFA is applied only to eligible services delivered by medical care providers to whom the MFA policy applies, as noted in the attached ADDENDUM, *Section III, Providers Subject To and Not Subject to the MFA Policy.*

5.3 Program Information Sources and How to Apply for MFA. Additional information about the MFA program and how to apply is summarized in the attached ADDENDUM, *Section IV, Program Information and Applying for MFA.*

5.3.1 Program Information. Copies of the MFA policy, application forms, instructions, and plain language summaries (i.e., policy summaries or program brochures) are available to the general public, without charge, from KFH/HP's website, by email, in person, or by US postal mail.

5.3.2 Applying for MFA. A patient can apply for the MFA program, during or following the care received from KFH/HP, in several ways including in person, by telephone, or by paper application.

5.3.2.1 Screening Patients for Public and Private Program Eligibility. KFH/HP provides financial counseling to patients applying for the MFA program to identify potential public and private health coverage programs that may help with health care access needs. A patient who is presumed eligible for any public or private health coverage programs is required to apply for those programs.

5.4 Information Needed to Apply for MFA. Complete personal, financial, and other information is required to verify a patient's financial status to determine eligibility for the MFA program, as well as for public and private health coverage programs. MFA may be denied due to incomplete information. Information can be provided in writing, in person, or over the telephone.

5.4.1 Verifying Financial Status. A patient's financial status is verified each time he or she applies for assistance. If a patient's financial status can be verified using external data sources, he or she may not be required to provide financial documentation.

5.4.2 Providing Financial and Other Information. If a patient's financial status cannot be verified using external data sources or the patient applies by mail, he or she may submit the information described in the MFA program application to verify his or her financial status.

5.4.2.1 Complete Information. MFA program eligibility is determined once all requested personal, financial, and other information is received.

5.4.2.2 Incomplete Information. A patient is notified in person, by mail, or by telephone if required information received is incomplete. The patient may submit the missing information within 30 days from the date the notice was mailed, the in-person conversation took place, or the telephone conversation occurred.

5.4.2.3 Requested Information Not Available. A patient who does not have the requested information described in the program application may contact KFH/HP to discuss other available evidence that may demonstrate eligibility.

5.4.2.4 No Financial Information Available. A patient is required to provide basic financial information (e.g. income, if any, and source) and attest to its validity when (1) his or her financial status cannot be verified using external data sources, (2) requested financial information is not available and (3) no other evidence exists that may demonstrate eligibility. Basic financial information and attestation is required from the patient when he or she:

5.4.2.4.1 Is homeless, or

5.4.2.4.2 Has no income, does not receive a formal pay stub from his or her employer (excluding those who are self-employed), receives monetary gifts, or was not required to file a federal or state income tax return in the previous tax year, or

5.4.2.4.3 Has been affected by a well-known national or regional event that has been qualified as a disaster by the state or federal government, or by a personal event that caused loss of, or inability to inhabit, his or her residence leaving the individual without health care, insurance, or financial documentation.

5.4.3 Prequalified Patients. A patient is presumed to meet the program eligibility criteria and is not required to provide personal, financial and other information to verify financial status when he or she:

5.4.3.1 Is enrolled in a Community MFA (CMFA) program to which patients have been referred and prequalified through (1) federal, state or local government, (2) a partnering community-based organization, or (3) at a KFH/HP sponsored community health event, or

5.4.3.2 Is enrolled in a KP Community Benefit program designed to support access to care for low-income patients and prequalified by designated KFH/HP personnel, or

5.4.3.3 Is enrolled in a credible means-tested health coverage program (e.g., Medicare Low Income Subsidy Program), or

5.4.3.4 Was granted a prior MFA award within the last 30 days.

5.4.4 Patient Cooperation. A patient is required to make a reasonable effort to provide all requested information. If all requested information is not provided, the circumstances are considered and may be taken into account when determining eligibility.

5.5 Presumptive Eligibility Determination. A patient who has not applied may be identified as eligible for the MFA program if his or her financial status can be validated through the use of external data sources. If determined to be eligible, he or she may automatically be assigned an MFA award and sent a notification letter with an option to decline medical financial assistance. A patient may be identified without applying when he or she:

5.5.1 Is uninsured and (1) has a scheduled appointment for eligible services at a KP facility, (2) has not indicated that he or she has health coverage, and (3) is presumed not eligible for Medicaid.

5.5.2 Has received care at a KP facility and there are indications of financial hardship (e.g., past due or outstanding balances).

5.6 Program Eligibility Criteria. As summarized in the attached ADDENDUM, *Section V, Eligibility Criteria*, a patient applying for MFA may qualify for financial assistance based on means-tested, or high medical expense criteria.

5.6.1 Means-Testing Criteria. A patient is evaluated to determine if he or she meets means-testing eligibility criteria.

5.6.1.1 Eligibility Based on Income Level. A patient of a household income less than or equal to KFH/HP's means testing criteria as a percentage of the Federal Poverty Guidelines (FPG) is eligible for financial assistance.

5.6.1.2 Household Income. Income requirements apply to the family members of the household. A family is a group of two or more persons related by birth, marriage, or adoption who live together. Family members can include spouses, qualified domestic partners, children, caretaker relatives, and the children of caretaker relatives that reside in the household.

5.6.2 High Medical Expense Criteria. A patient is evaluated to determine whether he or she meets high medical expense eligibility criteria.

5.6.2.1 Eligibility Based on High Medical Expenses. A patient of any household income level with incurred out-of-pocket medical and pharmacy expenses for eligible services over a 12 month period greater than or equal to KFH/HP's high medical expense criteria as a percentage of annual household income is eligible for financial assistance.

5.6.2.1.1 KFH/HP Out-of-Pocket Expenses. Medical and pharmacy expenses incurred at KP facilities include copayments, deposits, coinsurance, and deductibles related to eligible services.

5.6.2.1.2 Non-KFH/HP Out-of-Pocket Expenses. Medical, pharmacy, and dental expenses provided at non-KP facilities, related to eligible services, and incurred by the patient (excluding any discounts or write offs) are included. The patient is required to provide documentation of the medical expenses for the services received from non-KP facilities.

5.6.2.1.3 Health Plan Premiums. Out-of-pocket expenses do not include the cost associated with health insurance (i.e., premiums).

5.7 Denials and Appeals

5.7.1 Denials. A patient who applies for the MFA program and does not meet the eligibility criteria is informed either in writing or verbally that his or her request for MFA is denied.

5.7.2 How to Appeal an MFA Denial. A patient who believes that his or her application or information was not properly considered may appeal the decision. Instructions for completing the appeal process are included in the MFA denial letter. Appeals are reviewed by the designated KFH/HP staff.

5.8 Award Structure. MFA awards commence from the date of approval, or the date services were provided or the date medications were dispensed. MFA awards are applied to past due or outstanding balances only.

5.8.1 Basis of Award. The expenses paid by an MFA award are determined based on whether or not the patient has health care coverage.

5.8.1.1 MFA Eligible Patient without Health Care Coverage (Uninsured). An eligible uninsured patient receives a 100% discount on all eligible services.

5.8.1.2 MFA Eligible Patient with Health Care Coverage (Insured). An eligible insured patient receives 100% discount on that portion of a bill for all eligible services (1) for which he or she is personally responsible and (2) which is not paid by his or her insurance carrier. The patient is required to provide documentation, such as an Explanation of Benefits (EOB), to determine the portion of the bill not covered by insurance.

5.8.1.2.1 Payments Received from Insurance Carrier. An eligible insured patient is required to sign over to KFH/HP any payments for services provided by KFH/HP which the patient receives from his or her insurance carrier.

5.8.1.3 Reimbursements from Settlements. KFH/HP pursues reimbursement from third party liability settlements, payers, or other legally responsible parties, as applicable.

5.8.2 Award Duration. As summarized in the attached ADDENDUM, *Section VI, Award Duration,* the duration of an MFA award for an eligible patient is determined in various ways, including:

5.8.2.1 Specific Period of Time.

5.8.2.2 Course of Treatment or Episode of Care. For a particular course of treatment and/or episode of care as determined by a KP provider.

5.8.2.3 Patients Who Are Potentially Eligible for Public and Private Health Coverage Programs. An interim MFA award may be granted to assist a patient while he or she applies for public and private health coverage programs.

5.8.2.4 One-Time Pharmacy Award. Prior to applying to the MFA program, a patient is eligible for a one-time pharmacy award if he or she (1) does not have an MFA award, (2) fills a prescription written by a KP provider at a KFH/HP pharmacy, and (3) expresses an inability to pay for the prescription. The one-time award includes a reasonable supply of medication as determined medically appropriate by a KP provider.

5.8.2.5 Request for Award Extension. A patient may request extension of an MFA award as long as he or she continues to meet the MFA eligibility requirements. Extension requests are evaluated on a case-by-case basis.

5.8.3 Award Revoked, Rescinded, or Amended. KFH/HP may revoke, rescind, or amend an MFA award, in certain situations, at its discretion. Situations include:

5.8.3.1 Fraud, Theft, or Financial Changes. A case of fraud, misrepresentation, theft, changes in a patient's financial situation, or other circumstance which undermines the integrity of the MFA program.

5.8.3.2 Eligible for Public and Private Health Coverage Programs. A patient screened for public and private health coverage programs is presumed to be eligible but does not cooperate with the application process for those programs.

5.8.3.3 Other Payment Sources Identified. Health coverage or other payment sources identified after a patient receives an MFA award causes the charges for eligible services to be re-billed retroactively. If this occurs, the patient is not billed for that portion of a bill (1) for which he or she is personally responsible and (2) which is not paid by his or her health coverage or other payment source.

5.9 Limitation on Charges. Charging MFA eligible patients the full dollar amounts (i.e., gross charges) for eligible hospital services rendered at a Kaiser Foundation Hospital is prohibited. A patient who has received eligible hospital services at a Kaiser Foundation Hospital and is qualified for the MFA program, but has not received an MFA award or has declined an MFA award, is not charged more than the amounts generally billed (AGB) for those services.

5.9.1 Amounts Generally Billed. The amounts generally billed (AGB) for emergency or other medically necessary care to individuals who have insurance covering such care are determined for KP facilities as described in the attached ADDENDUM, *Section VII, Basis for Calculating Amounts Generally Billed (AGB).*

5.10 Collection Actions.

5.10.1 Reasonable Notification Efforts. KFH/HP or a collection agency acting on its behalf makes reasonable efforts to notify patients with past due or outstanding balances about the MFA program. Reasonable notification efforts include:

5.10.1.1 Providing one written notice within 120 days of first post-discharge statement informing account holder that MFA is available for those who qualify.

5.10.1.2 Providing written notice with the list of extraordinary collection actions (ECAs) that KFH/HP or a collection agency intends to initiate for payment of balance, and the deadline for such actions, which is no earlier than 30 days from written notice.

5.10.1.3 Providing a plain language summary of the MFA policy with the first hospital patient statement.

5.10.1.4 Attempting to notify the account holder verbally about the MFA policy and how to obtain assistance through the MFA application process.

5.10.2 Extraordinary Collection Actions Suspended. KFH/HP does not conduct or permit collection agencies to conduct on its behalf, extraordinary collection actions (ECAs) against a patient if he or she:

5.10.2.1 Has an active MFA award, or

5.10.2.2 Has initiated an MFA application after ECAs have begun. ECAs are suspended until a final eligibility determination is made.

5.10.3 Allowable Extraordinary Collection Actions.

5.10.3.1 Final Determination of Reasonable Efforts. Prior to initiating any ECAs, the regional Revenue Cycle Patient Financial Services Leader ensures the following:

5.10.3.1.1 Completion of reasonable efforts to notify the patient of the MFA program, and

5.10.3.1.2 The patient has been provided at least 240 days from the first billing statement to apply for MFA.

5.10.3.2 Reporting to Consumer Credit Agencies or Credit Bureaus. KFH/HP or a collection agency acting on its behalf may report adverse information to consumer credit reporting agencies or credit bureaus.

5.10.3.3 Judicial or Civil Actions. Prior to pursuing any judicial or civil actions, KFH/HP validates the patient's financial status through the use of external data sources to determine if he or she is eligible for the MFA program.

5.10.3.3.1 Eligible for MFA. No additional actions are pursued against patients that are eligible for the MFA program. Accounts that qualify for MFA are cancelled and returned on a retrospective basis.

5.10.3.3.2 Not Eligible for MFA. In very limited cases, the following actions may be conducted with prior approval from the regional Chief Financial Officer or Controller:

5.10.3.3.2.1 Garnishment of wages

5.10.3.3.2.2 Lawsuits/civil actions. Legal action is not pursued against an individual who is unemployed and without other significant income.

5.10.3.3.2.3 Liens on residences.

5.10.4 Prohibited Extraordinary Collection Actions. KFH/HP does not perform, allow, or allow collection agencies to perform, the following actions under any circumstance:

5.10.4.1 Defer, deny, or require payment, due to an account holder's nonpayment of a previous balance, before providing emergency or medically necessary care.

5.10.4.2 Sell an account holder's debt to a third party.

5.10.4.3 Foreclosure on property or seizure of accounts.

5.10.4.4 Request warrants for arrest.

5.10.4.5 Request writs of body attachment.

6.0 References / Appendices

6.1 Appendix A – Glossary of Policy Terms

6.2 Laws, Regulations, and Resources

6.2.1 Patient Protection and Affordable Care Act, Public Law 111-148 (124 Stat. 119 (2010))

6.2.2 Federal Register and the Annual Federal Poverty Guidelines

6.2.3 Internal Revenue Service Publication, 2014 Instructions for Schedule H (Form 990)

6.2.4 Internal Revenue Service Notice 2010-39

6.2.5 Internal Revenue Service Code, 26 CFR Parts 1, 53, and 602, RIN 1545-BK57; RIN 1545-BL30; RIN 1545-BL58 – Additional Requirements for Charitable Hospitals

6.2.6 California Hospital Association – Hospital Financial Assistance Policies & Community Benefit Laws, 2015 Edition

6.2.7 Catholic Health Association of the United States – A Guide for Planning & Reporting Community Benefit, 2012 Edition

6.3 Provider Lists

6.3.1 Provider lists are available at the KFH/HP websites for:

6.3.1.1 Kaiser Permanente of Hawaii

6.3.1.2 Kaiser Permanente of Northwest

6.3.1.3 Kaiser Permanente of Northern California

6.3.1.4 Kaiser Permanente of Southern California

Appendix A

Glossary of Policy Terms

Charity Care is medical or health services, products, or medication provided at reduced or no cost to patients who do not have the ability to pay and/or are not covered by health care insurance.

Community MFA (CMFA) refers to planned charity care programs that collaborate with community based and safety net organizations to provide charity care services to low income uninsured and underinsured patients at KP facilities.

Durable Medical Equipment (DME) includes, but is not limited to, standard canes, crutches, nebulizers, intended benefitted supplies, over the door traction units for use in the home, wheelchairs, walkers, hospital beds, and oxygen for use in the home as specified by DME criteria. DME does not include orthotics, prosthetics (e.g., dynamic splints/orthoses, and artificial larynx and supplies) and over-the-counter supplies and soft goods (e.g., urological supplies and wound supplies).

Eligible Patient is an individual who meets the eligibility criteria described in this policy, whether he or she is (1) uninsured; (2) receives coverage through a public program (e.g., Medicare, Medicaid, or subsidized health care coverage purchased through a health information exchange); (3) is insured by a health plan other than KFHP; or (4) is insured by KFHP.

External Data Sources are third-party vendors, credit reporting agencies, etc., that provide financial status information used by KP to validate or confirm a patient's financial status when assessing eligibility for the MFA program.

Federal Poverty Guidelines (FPG) establishes the levels of annual income for poverty as determined by the United States Department of Health and Human Services and are updated annually in the Federal Register.

Financial Counseling is the process used to assist patients to explore the various financing and health coverage options available to pay for services rendered in KP facilities. Patients who may seek financial counseling include, but are not limited to, self-pay, uninsured, underinsured, and those who have expressed an inability to pay the full patient liability.

Homeless describes the status of a person who resides in one of the places or is in a situation described below:

- In places not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings (on the street); or
- In an emergency shelter; or
- In transitional or supportive housing for homeless persons who originally came from the streets or emergency shelters.
- In any of the above places but is spending a short time (up to 30 consecutive days) in a hospital or other institution.

- Is being evicted within a week from a private dwelling unit or is fleeing a domestic violence situation with no subsequent residence identified and the person lacks the resources and support networks needed to obtain housing.
- Is being discharged within a week from an institution, such as a mental health or substance abuse treatment facility in which the person has been a resident for more than 30 consecutive days and no subsequent residence has been identified and the person lacks the financial resources and social support networks needed to obtain housing.

KP includes Kaiser Foundation Hospitals, Kaiser Foundation Health Plans, Permanente Medical Groups, and their respective subsidiaries, except Kaiser Permanente Insurance Company (KPIC).

KP Facilities include any physical premises, including the interior and exterior of a building, owned or leased by KP in the conduct of KP business functions, including patient care delivery (e.g., a building, or a KP floor, unit, or other interior or exterior area of a non-KP building).

Means-Tested is the method by which external data sources or information provided by the patient are used to determine eligibility for a public coverage program or MFA based on whether the individual's income is greater than a specified percentage of the Federal Poverty Guidelines.

Medical Financial Assistance (MFA) provides monetary awards to pay medical costs to eligible patients who are unable to pay for all or part of medically necessary services, and who have exhausted public and private payer sources. Individuals are required to meet program criteria for assistance to pay some or all of the cost of care.

Medical Supplies refer to non-reusable medical materials such as splints, slings, wound dressings, and bandages that are applied by a licensed health care provider while providing a medically necessary service, and excluding those materials purchased or obtained by a patient from another source.

Pharmacy Waiver provides financial assistance to low-income KP Senior Advantage Medicare Part D members who are unable to afford their cost share for outpatient prescription drugs covered under Medicare Part D.

Safety Net refers to a system of nonprofit organizations and/or government agencies that provide direct medical care services to the uninsured in a community setting such as a public hospital, community clinic, church, homeless shelter, mobile health unit, school, etc.

Underinsured is an individual who, despite having health care coverage, finds that the obligation to pay insurance premiums, copayments, coinsurance, and deductibles is such a significant financial burden that he or she delays or does not receive necessary health care services due to the out-of-pocket costs.

Uninsured is an individual who does not have health care insurance or federal- or state-sponsored financial assistance to help pay for the health care services.

Vulnerable Populations include demographic groups whose health and well-being are considered to be more at-risk than the general population due to socioeconomic status, illness, ethnicity, age, or other disabling factors.

Writ(s) of Body Attachment is a process initiated by a court directing the authorities to bring a person found to be in civil contempt before the court, similar to an arrest warrant.

ADDENDUM: Kaiser Permanente Mid-Atlantic States

I. **Kaiser Foundation Hospitals:** This policy does not apply to any hospitals in the Mid-Atlantic Region.

II. **Additional Services Eligible and Not Eligible Under the MFA Policy.**

a. **Additional Non-Eligible Services.**

i. Most Durable Medical Equipment

ii. Emergency and non-emergency transportation

iii. Hearing aids

iv. Optical supplies (i.e., glasses or contacts)

III. **Providers Subject To and Not Subject to the MFA Policy.** Not applicable.

IV. **Program Information and Applying for MFA.** MFA program information, including copies of the MFA policy, application forms, instructions, and plain language summaries (i.e., program brochures), is available to the general public, without charge, in electronic format or hard copy. A patient can apply for the MFA program, during or following the care received from KFH/HP, in several ways including in person, by telephone, or by paper application. (Refer to Sections 5.3 and 5.4 above.)

a. **Download Program Information from the KFH/HP Website.** Electronic copies of program information are available on the MFA website at www.kp.org/mfa/mas.

b. **Request Program Information Electronically.** Electronic copies of program information are available by email upon request.

c. **Obtain Program Information or Apply In Person.** Counselors are available at KP facilities to provide program information. Counselors are available at the Administration Department in each KP medical office building.

d. **Request Program Information or Apply by Telephone.** Counselors are available by telephone to provide information, determine MFA eligibility, and assist a patient to apply for MFA. Counselors can be reached at:

Telephone Number(s): 301-816-6615

e. **Request Program Information or Apply by Mail.** A patient can request program information and apply for MFA by submitting a complete MFA program application by mail. Information requests and applications can be mailed to:

Kaiser Permanente
Attention: Medical Financial Assistance Program
2101 East Jefferson Street
Rockville, MD 20852-9468

f. **Personally Deliver Completed Application.** Completed applications can be delivered in person to any KP medical office building.

V. **Eligibility Criteria.** A patient's household income and medical expenses are considered when determining MFA eligibility. (Refer to Sections 5.6.1. and 5.6.2 above.)

a. Means Testing Criteria: Up to 300% of the Federal Poverty Guidelines

b. High Medical Expense Criteria: 20% or more of annual household income

VI. **Award Duration.** MFA awards commence from the date of approval, or the date services were provided, or the date medications were dispensed. An MFA award is in effect for a limited period of time. (Refer to Sections 5.8.2 above.)

a. Maximum duration based on specific time period:

i. Standard award for eligible services: Up to 180 days

ii. Presumptive eligibility award for uninsured patients: 30 days

b. Maximum duration for course of treatment / episode of care: Up to 180 days

c. Maximum duration for uninsured patients who are potentially eligible for public and private health coverage programs: Up to 180 days

d. Maximum duration for one-time pharmacy award: 30 days

VII. **Basis for Calculating Amounts Generally Billed (AGB).** KFH/HP determines AGB for any emergency or other medically necessary care using the look back method by multiplying the gross charges for the care by the AGB rate. Information regarding the AGB rate and calculation is available on the KFH/HP MFA website at www.kp.org/mfa/mas.

Exhibit 3

Mid-Atlantic

Add to Collection

Medical Financial Assistance Program

- Who is eligible? »
- What does the program cover? »
- How do I apply? »
- Other programs and resources »
- Need help? »

Having trouble paying for your Kaiser Permanente medical and pharmacy expenses?

Kaiser Foundation Hospitals and Kaiser Foundation Health Plans, collectively referred to as Kaiser Permanente, are committed to providing programs that facilitate access to care for vulnerable populations. This commitment includes providing financial assistance to qualified low income, uninsured and underinsured patients when the ability to pay for services is a barrier to accessing emergency and medically necessary care. Patients must meet the eligibility requirements below to qualify.

Who is eligible for Financial Assistance and what are the requirements?

The Medical Financial Assistance (MFA) program helps low-income, uninsured, or underinsured patients who need help paying for all or part of their medical care received from Kaiser Permanente. Patients are eligible for financial assistance when their family income is at or below 300% of the Federal Poverty Guidelines (FPG). Patients should consult with a counselor to determine eligibility and for assistance applying. Patients who have experienced unusually high medical expenses may be eligible for the program, regardless of household income. Refer to the MFA Policy for a complete description of the program eligibility requirements.

What does the program cover?

The MFA program covers emergency and medically necessary health care services, pharmacy services and products, and medical supplies provided at Kaiser Permanente facilities (i.e. hospitals, medical centers, and medical office buildings), at Kaiser Permanente outpatient pharmacies, or by Kaiser Permanente providers. Services that are not considered emergent or medically necessary as determined by a Kaiser Permanente provider include, but are not limited to cosmetic surgery or services, infertility treatments, retail medical supplies, surrogacy services, and services related to third party liability, or workers' compensation cases. Refer to the MFA Policy for a complete list of eligible and ineligible services.

How can I get program information?

Copies of the MFA policy, application forms, instructions, and plain language summaries (e.g., policy summaries or program brochures) are available to the general public, without charge, from Kaiser Permanente's website, by email, in person, by telephone, or by U.S. postal mail.

Download program information: Electronic copies of program information are available:

Medical Financial Assistance Policy (English) Click here for more languages Spanish, Vietnamese

Program Summary (English)

Program Application (English) Click here for more languages Spanish Vietnamese

Request program information electronically: Electronic copies of program information are available by email upon request. Call 301-816-6615 to request electronic copies. Please be prepared to provide an email address that the information can be sent to when calling.

Obtain program information in person: Counselors are available at Kaiser Permanente facilities to provide program information. Counselors are available at the Administration Department in each Kaiser Permanente medical office building.

Request program information by telephone: Counselors are available by telephone to provide information, determine MFA eligibility, and assist a patient to apply for MFA. Counselors can be reached at: 301-816-6615, Monday – Friday, 8:30 a.m. – 4:30 p.m.

Request program information by U.S. postal mail: A patient can request program information by mail. Information requests can be mailed to:

Kaiser Permanente
Attention: Medical Financial Assistance Program
2101 East Jefferson Street
Rockville, MD 20852-9468

How do I apply?

A patient can apply for the MFA program, during or following the care received from Kaiser Permanente, in several ways including in person with a counselor, or by submitting a complete paper application.

Apply in person: Counselors are available at Kaiser Permanente facilities to provide program information. Counselors are available at the Administration Department in each Kaiser Permanente medical office building.

Complete and submit a program application: Please mail completed applications (including all required documentation and information specified in the application instructions) to:

Kaiser Permanente
Attention: Medical Financial Assistance Program
2101 East Jefferson Street
Rockville, MD 20852-9468

Kaiser Permanente will review submitted applications when they are complete and will determine whether you are eligible according to the Kaiser Permanente Medical Financial Assistance Policy. Incomplete applications may result in a delay in processing or denial of your MFA application, but Kaiser Permanente will notify applicants and provide an opportunity to send in the missing documentation or information, by the required deadline.

Amounts Generally Billed (AGB)

Amounts Generally Billed (AGB) is based on the average of the lowest average of the amounts that were paid to a Kaiser facility by private health insurers, Medicare fee-for-service and Medicaid fee-for-service (and co-pays and deductibles) for emergency or medically necessary services, based on actual claim data from November 1, 2014 to October 31, 2015, which is consistent with the look-back method. Total expected payment from allowed claims was divided by total billed charges for such claims, and that number was subtracted from 1 to calculate the AGB percentage. The 2016 AGB reduction to gross charges is 19%.

Is there language assistance?

Interpreters are available to you at no cost. The medical financial assistance application, policy, and the policy summary may be available in your language. For more information, call 1-301-816-6615.

Other beneficial programs and extra resources:

If you don't have health care coverage and would like more information, visit healthcare.gov or call 1-800-318-2596.

This may be a hard time for you financially. If you need help paying for needs other than health care, there are community resources and programs that can help. For more information on programs that may save you money, visit myadvocatehelps.com. Examples include:

- Food stamps through the Supplemental Nutrition Assistance Program (SNAP)

- Local food pantries and community centers
- Transportation assistance

Need help?

For help or questions about the Medical Financial Assistance application process or other questions, please call 1-301-816-6615, or speak to a MFA Specialist within the MFA Department or the Administration office at your local Kaiser Permanente Medical Center Building.

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Kaiser Permanente Share
News, views and moves from one of America's leading health care providers and not-for-profit health plans

Exhibit 4

October 22, 2014

Organization #:	**103297**	**Program Type:**	**Ambulatory Surgery Center**
Organization:	**Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. dba South Baltimore County Medical Center ASC**		
Address:	**1701 Twin Springs Road**		
City, State, Zip:	**Halethorpe, MD 21227**		
Decision Recipient:	**Kathy Miller, RN, MBA, MSN, CHC**		
Survey Date:	**September 18-19, 2014**	**Type of Survey:**	**Initial Accreditation/Initial Medicare Deemed Status Survey**
Deficiency Level:	**Standard**	**Correction Method:**	**Plan of Correction Self-Attestation Document Review**
Accreditation Type:	**Full Accreditation**	**Recommended Medicare Deemed Status:**	**Yes**
Acceptable Plan of Correction Received:	**October 6, 2014**	**Correction Timeframe:**	**September-2014 to October-2014**
Accreditation Term Begin:	**October 6, 2014**	**Accreditation Term Expires:**	**October 6, 2017**
Special CC:	**CMS CO - Baltimore CMS RO III- Philadelphia**	CMS Certification Number (CCN):	**Pending**

Accreditation Renewal Code: **db0d7ed9103297**
Complimentary study participation code: **103297FREEIQI**

We hope the survey has been beneficial to your organization in identifying its strengths and opportunities to improve. AAAHC trusts that you will continue to find the accreditation experience meaningful, not only from the benefit of having carefully reviewed your own operation, but also from the recognition brought by your participation in this survey process.

Granting accreditation reflects confidence, based on evidence from this recent survey that you meet, and will continue to demonstrate throughout the accreditation term, the attributes of an accreditable organization, as reflected in the standards found in the *Accreditation Handbook for Ambulatory Health Care*. The dedication and effort necessary for an organization to be accredited is substantial and the compliance with those standards implies a commitment to continual self-evaluation and continuous improvement.

As an ambulatory surgery center (ASC) that had an AAAHC/Medicare deemed status survey, your ASC has demonstrated its compliance with not only the AAAHC standards, but also all Medicare Conditions for Coverage (CfC). Your ASC is recommended for participation in the Medicare deemed status program. CMS has the final authority to determine participation in Medicare Deemed Status.

Members of your organization should take time to review your Survey Report, which may arrive separately:

- Any standard marked "PC" (Partially Compliant) or "NC" (Non-Compliant) must be corrected promptly. Subsequent surveys by the AAAHC will seek evidence that deficiencies from this survey were addressed without delay.
- The Summary Table provides an overview of compliance for each chapter applicable to the organization.

- As a guide to the ongoing process of self-evaluation, periodic review of the Survey Report and the current year's *Handbook* will ensure the organization's ongoing compliance with the standards throughout the term of accreditation.

AAAHC policies and procedures and standards are revised on an annual basis, such revisions become effective March 1 each year. Accredited organizations are required to maintain their operations in compliance with the current AAAHC standards and policies. Therefore, the organization is encouraged to visit the AAAHC website, www.aaahc.org, for information pertaining to any revisions to AAAHC policies and procedures and standards.

In order to ensure continuation of accreditation, your organization should submit an application for survey approximately five months prior to your accreditation expiration. According to our *Accreditation Handbook*,

> *Currently-accredited organizations must complete and submit the Application for Survey, supporting documentation, and application fee for their subsequent full accreditation survey (referred to as a re-accreditation survey). Please visit www.aaahc.org to complete the Application for Survey and for further information. After review of an organization's completed Application for Survey and supporting documentation, the AAAHC will contact the organization to establish survey dates. To prevent a lapse in accreditation, an organization should ensure that all documentation is submitted to the AAAHC at least five (5) months prior to its accreditation expiration date. In states where accreditation is mandated by law, an organization should submit the completed Application for Survey and other required documentation a minimum of six (6) months prior to its accreditation expiration date.*

For submission of an application for survey, your organization will need the "*accreditation renewal code*" located underneath the accreditation expiration date.

You will notice that you have a "*complimentary study participation code*" at the top of this letter. You may use this to register for one of the AAAHC Institute for Quality Improvement's studies. Please visit www.aaahc.org/institute for additional information or contact Michelle Chappell, at 847-324-7747 or mchappell@aaahc.org.

If you have any questions or comments about any portion of the accreditation process, please contact the AAAHC Accreditation Services department at (847) 853-6060.

ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

Preparing for Reaccreditation

To maintain AAAHC accreditation, your organization must undergo a full survey at least once every three years. Your organization may be required to undergo an interim survey or a Medicare follow-up survey within the three-year term to determine ongoing compliance with the accreditation Standards. The following information is also posted in a checklist format under the "Timeline Tasks" section of the web-based e-application.

WHEN?	WHAT?
TODAY	▶ Use the *Survey Report* and, if applicable, your organization's Plan for Improvement or Plan of Correction, as guides to the ongoing process of self-evaluation. ▶ Begin to bring your organization into substantial compliance with any "PC" (Partially Compliant) or "NC" (Non-Compliant) Standards and prepare a record of that activity. Any such Standards will be identified in your *Survey Report*, and in your organization's Plan for Improvement or Plan of Correction if you were required to create one of these plans. ▶ If applicable, prepare for your organization's interim survey or Medicare follow-up survey.
TWO YEARS prior to accreditation expiration	▶ Review the current year's AAAHC Standards. ▶ Review your organization's operations, and implement adjustments as necessary in order to maintain compliance with any new or revised Standards. ▶ If required, complete an interim survey
ONE YEAR prior to accreditation expiration	▶ Review the current year's AAAHC Standards. ▶ Review your organization's operations, and implement adjustments as necessary in order to maintain compliance with any new or revised Standards. ▶ If required, complete an interim survey.
SEVEN - NINE MONTHS prior to accreditation expiration	▶ Begin preparing the application for survey, accessible through the AAAHC website at www.aaahc.org. ▶ The application for survey includes the application form and a list of documents to be submitted with the application.
FIVE MONTHS prior to accreditation expiration	**TO AVOID A LAPSE IN ACCREDITATION:** ▶ Submit application materials five months prior to accreditation expiration.

Please refer to your AAAHC accreditation decision letter or AAAHC Certificate of Accreditation for your organization's expiration date.

Ambulatory surgery centers: If your organization wishes to opt for Medicare Deemed Status on your next survey, please review the requirements for Medicare Deemed Status outlined within the current year's *Accreditation Handbook Including Medicare Requirements for Ambulatory Surgery Centers (ASCs).*

All accredited organizations are required to maintain their operations in compliance with ***current*** AAAHC Standards and policies and procedures, which may change from year to year. New standards become effective on March 1 of each year. An application for survey received on or after March 1 is reviewed by the Standards contained in the current year's *Handbook*.

ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC

Dear Organization:

The Accreditation Association for Ambulatory Health Care (AAAHC) is pleased to provide the Consultative Report from your recent AAAHC/Medicare deemed status survey. This report is provided in the spirit of accreditation to assist your organization in providing high quality health care to your patients. The comments provided in this Consultative Report are for your review and reflection, and are offered as suggestions to help your organization meet AAAHC standards. These comments were not considered as part of your organization's accreditation decision.

It is our sincere hope that you will continue to find the accreditation experience worthwhile as your organization continues to grow and mature.

If you have any questions or comments, please contact AAAHC at (847) 853-6060.

Sincerely,

Michon Villanueva
Director, Accreditation Services

Encl.

CONSULTATIVE COMMENTS

Chapter	Consultative Comments
6 - Clinical Records	Suggest maintaining a copy of the anesthesia record in the ASC until the scanned copy is available in the EMR.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF HEALTH CARE QUALITY

SPRING GROVE CENTER
BLAND BRYANT BUILDING
55 WADE AVENUE
CATONSVILLE, MARYLAND 21228

License No. KFSB1

Issued to: **Kaiser Foundation Health Plan- South Baltimore County ASC**
1701 Twin Springs Road
Halethorpe, MD 21227

Type of Facility or Community Program: **Ambulatory Surgery Center**

Date Issued: April 3, 2013

SPECIALTIES: Endoscopy, General, Gastrointestinal Procedures, General, OB/GYN, Ophthalmology, Orthopedic, Otolaryngology, Pain Management, Plastic Surgery Podiatric

Authority to operate in this State is granted to the above entity pursuant to The Health-General Article, Title 19 Annotated Code of Maryland, including all applicable rules and regulations promulgated there under. This document is not transferable.

Expiration Date: April 3, 2016

Patricia Tomaka May, M.D.

Director

Falsification of a license shall subject the perpetrator to criminal prosecution and the imposition of civil fines.

Exhibit 5

PATIENT TRANSFER AGREEMENT

This Patient Transfer Agreement ("Agreement"), effective Monday April 1, 2013, is made by and between Saint Agnes Healthcare, Inc. d/b/a Saint Agnes Hospital ("Hospital"), a nonprofit corporation organized under the laws of Maryland, and **KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.**, a Maryland nonprofit corporation ("Kaiser").

WHEREAS, Kaiser operates a Maryland licensed ambulatory surgery center located at 1701 Twin Springs Road, Baltimore, Maryland 21227 ("Facility") whose patients are periodically in need of acute care services not available at the Facility; and

WHEREAS, Hospital provides acute care services and is capable of providing full surgical, anesthesia, clinical laboratory and diagnostic radiology service on 30 minutes notice and has a physician in its hospital available for providing emergency services at all times, and is willing to provide such services to Facility patients in need of such services; and

WHEREAS, the parties desire to formalize an agreement whereby Facility patients, regardless of payor sources, in need of emergency care and other medical services not available at the Facility are transferred to the appropriate institution for various levels of medical or surgical care according to the dictates of the patients' medical conditions as judged by attending and consultant physicians.

THEREFORE, in consideration of the mutual covenants and promises contained herein, it is understood and agreed upon by and between the parties hereto as follows:

AGREEMENT

1. Maintenance of Control. Each party shall have exclusive control of the management, assets and affairs of its respective institutions. Unless expressly stated elsewhere in this Agreement, neither party assumes any liability, debt or obligation incurred by the other party to this Agreement. Neither party shall assume responsibility for the care rendered to Kaiser patients by the other party.

2. Transfer of Patients. When a Kaiser patient's need for transfer from the Facility to Hospital has been determined by the attending physician, Hospital agrees to admit the patient as promptly as possible, provided customary admission requirements are met, State and Federal laws and regulations are met, and Hospital has the capacity to treat the patient. Notice of the transfer shall be given to Hospital by Kaiser as far in advance as possible. Hospital shall give prompt confirmation of whether it can provide medical care appropriate to the patient's medical needs. Kaiser shall assume primary responsibility for arranging appropriate medical transport services to Hospital. Kaiser shall consult (a) Hospital emergency department physician or (b) Hospital admission department (for a direct admission), as appropriate, in regards to arrangements and details of the transfer, including transportation, to ensure optimal care of the patient.

3. Patient Assessment. The patient's condition will be assessed by the attending physician using emergency and other appropriate criteria developed by Kaiser. In those cases where the

attending physician concludes that the patient's condition requires the services of Hospital, Kaiser will initiate the transfer to the Hospital. To initiate the transfer, Kaiser will call (a) Hospital's emergency department designated individual taking calls for emergency services of Hospital or (b) Hospital's admission department for a direct admission to the Hospital, as appropriate. Kaiser will contact Hospital prior to the transfer of the patient and provide a brief report to Hospital regarding the patient's condition which shall include, but not be limited to, the following:

a. Name;
b. Age;
c. Medical history;
d. Current condition; and
e. Mode of transport/estimated time of arrival.

4. Mutual Indemnity. Each party hereto agrees to indemnify, defend and hold the other party harmless against all actions, claims and demands whatsoever, including costs, expenses and reasonable attorney's fees, resulting from any intentional or negligent acts or omissions of the indemnifying party or its employees or independent contractors engaged in the provisions of services under this Agreement.

5. Hospital Emergency Services. Hospital, consistent with its obligations under the Emergency Medical Treatment and Active Labor Act ("EMTALA"), will provide medical personnel to assess and stabilize patients who come to the Hospital's emergency department.

6. Patient Information. Kaiser agrees to send Hospital with each patient at the time of transfer whatever records available at the time of transfer and all medical records related to the patient's condition regarding the transfer. If Kaiser is unable to send the pertinent information and medical records at the time of the transfer of the patient, Kaiser agrees to do so as promptly as possible, and no later than one working day after the date of transfer. Hospital agrees to provide Kaiser with follow-up information on the status of transferred patients as requested by Kaiser. All patient information shall be transferred to Hospital in accordance with all federal and state privacy mandates.

7. Patient Belongings. Kaiser shall be responsible for the transfer or other appropriate disposition of any personal belongings of the patient.

8. Reimbursement. Each party hereto shall be responsible for billing and collecting from the patient, third party payor, or other responsible party for the items and services rendered to the patient by such party. Neither party shall be liable to the other for such charges, nor be entitled to compensation from the other party for any services provided under, or pursuant to this Agreement. When a Kaiser patient is no longer in need of Hospital's acute care services, the patient will be discharged from Hospital, transferred to another facility, or transferred back to Kaiser, according to the patient's medical condition and consent.

9. Non-Discrimination. Neither party shall discriminate against any patient on the grounds of ability to pay, race, sex, color, age, religion, national origin, disability, or health status.

10. Term and Termination. This Agreement shall be effective as of the date first set forth above and will continue in effect until terminated as herein provided. Either party may terminate this Agreement upon giving at least thirty (30) days written notice to the other party. In addition, this Agreement will automatically terminate immediately if either party fails to maintain its

license or certification as required by applicable state or federal laws, its ability to participate in the Medicare and/or Medicaid programs is terminated, or if it loses accreditation by The Joint Commission.

11. Nonexclusively. Nothing in this Agreement will be construed as limiting the right of either party to affiliate or contract with any other party for similar services while this Agreement is in effect.

12. Amendment. This Agreement, in whole or in part, may be amended at any time only by mutual written consent of both parties.

13. Assignment. Neither party shall assign this Agreement without the prior written consent of the other party.

14. Compliance with Applicable Law. Each party shall comply with all applicable standards, including, but not limited to: (a) the standards of the party's applicable accreditation agency, and (b) federal, state and local government laws, rules and regulation, including EMTALA regulations.

15. Governing Law. This Agreement shall be governed and determined by the laws of the State of Maryland (excluding its conflict of laws provisions).

16. Medicare. Both parties agree, for four (4) years after the furnishing of services under this Agreement, to make available and provide, upon written request to the Secretary of Health and Human Services or upon request, to the Comptroller General of the United States of America, or any of their duly authorized representatives, the contracts, books, documents and records necessary to certify the nature and extent of reimbursable costs under Medicare. If either party carries out any of the terms of this Agreement via a subcontract with a value or cost of $10,000.00 or more over a twelve (12) month period with a related organization, such subcontract shall contain a requirement identical to that set forth in this paragraph.

17. Notice. Any notice required under this Agreement shall be in writing, and shall be deemed delivered when personally delivered, with acknowledged receipt, or three days after the same is sent by certified mail, postage prepaid, return receipt requested as follows:

If to Hospital:

Shirley Sutton, Director of Managed Care
900 Caton Avenue, Box 036
Baltimore, Maryland 21229

Attention:

If to Kaiser:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson Street
Rockville, MD 20852
Attention:

cc: Regional Counsel
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson Street
Rockville, MD 20852

18. Independent Contractors. The parties hereto shall at all times be deemed independent contractors. Their employees, agents, contractors or subcontractors shall not be regarded as employees or agents of one another for any purpose, including but not limited to payment of any taxes, FICA, unemployment, worker's compensation, fringe benefits, or with regard to any intentional or negligent activity in which they may be involved, or for any other purposes. Neither party shall use the name of the other party in any promotion or advertising unless prior written approval of the intended use is obtained from the party whose name is to be used.

19. Insurance. Each party shall secure and maintain in force during the term of this Agreement, insurance coverage for comprehensive general liability, professional liability and automobile insurance coverage with minimum limits of one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) annual aggregate. Upon request, the parties shall produce certificates of insurance which state that the above coverages are in force and will continue in force throughout the term of this Agreement. A thirty (30) day prior written notice of expiration, cancellation or substantial change in coverage shall be given to the other party. An adequate program of self-insurance program may be accepted in lieu of the foregoing commercial insurance.

20. Entirety. This Agreement contains the entire understand between the parties with respect to its subject matter. All prior negotiations between the parties are merged in this Agreement and there are no understandings or agreements other than those incorporated herein.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date first set forth above.

SAINT AGNES HEALTHCARE, INC. D/B/A SAINT AGNES HOSPITAL
By:

Printed Name: YOLANDA COPELAND
Title: SR VP Patient Care/CNO
Date: 12/18/12

Tax id number: 52-0591657

KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.
By:

Printed Name: Linda Collins
Title: Chief Operating Officer
Date: 1/2/13

Exhibit 6

January 27, 2016

To Whom It May Concern:

The project under consideration is the tenant fit-out of one (1) currently shelled Outpatient Operating Room, referred to as OR-03, located at Kaiser Permanente - South Baltimore County Medical Center – ASC.

The existing building was designed and constructed to accommodate the increased case load from the fit-out of OR-03. This includes the sizing of waiting areas, pre-operative holding, PACU, staff stations, semi-restricted and restricted areas and building engineering systems.

The requirements of an Outpatient Operating Room as defined by Section 3.7 of the 2010 edition of the FGI Guidelines include:

- "Class B Operating Rooms shall have a minimum clear floor area of 250 square feet with a minimum clear dimension of 15 feet between fixed cabinets and built-in shelves.
- Class C Operating Rooms shall have a minimum clear floor area of 400 square feet with a minimum clear dimension of 18 feet between fixed cabinets and built-in shelves.
- At least one scrub position must be located next to the entrance of each operating room."

The design of OR-03 complies with Section 3.7 of the 2010 FGI Guidelines for Design and Construction of Healthcare Facilities currently enforced by the State of Maryland. These guidelines are based on considerations of minimizing infection risks and assuring sterility and appropriate air filtration and ventilation for operating rooms.

Sincerely,
HDR Architecture, Inc.

Mark Nicasio, Project Manager
AIA, NCARB, GGP, GPCP

hdrinc.com

3001 Washington Boulevard, Suite 200
Arlington VA 222001
703.518.8500

Exhibit 7

KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.

Statutory Financial Statements and Statutory Supplemental Schedules

December 31, 2014 and 2013

(With Independent Auditors' Report Thereon)

KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.

Table of Contents

KPMG LLP
1676 International Drive
McLean, VA 22102

Independent Auditors' Report

The Board of Directors
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.:

We have audited the accompanying financial statements of Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Health Plan), which comprise the statutory statements of admitted assets, liabilities, capital, and surplus as of December 31, 2014 and 2013, and the related statutory statements of revenues and expenses, changes in capital and surplus, and cash flow for the years then ended, and the related notes to the statutory financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with statutory accounting practices prescribed or permitted by the Maryland Insurance Administration (MIA). Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of 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 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 financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the 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 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 financial statements.

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

Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

As described in Note 2 to the financial statements, the financial statements are prepared by Health Plan using statutory accounting practices prescribed or permitted by the MIA, which is a basis of accounting other than U.S. generally accepted accounting principles. Accordingly, the financial statements are not intended to be presented in accordance with U.S. generally accepted accounting principles.

The effects on the financial statements of the variances between the statutory accounting practices and U.S. generally accepted accounting principles also are described in Note 2.

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the significance of the variances between statutory accounting principles and U.S. generally accepted accounting principles discussed in the Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles paragraph, the financial statements referred to above do not present fairly, in accordance with U.S. generally accepted accounting principles, the financial position of Health Plan as of December 31, 2014 and 2013, or the results of its operations or its cash flows for the years then ended.

Opinion on Statutory Basis of Accounting

In our opinion, the financial statements referred to above present fairly, in all material respects, the admitted assets, liabilities, capital, and surplus of Health Plan as of December 31, 2014 and 2013, and the results of its operations and its cash flow for the years then ended, in accordance with statutory accounting practices prescribed or permitted by the MIA described in Note 2.

Other Matter

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplementary information included in the Summary Investment Schedule and Investment Risks Interrogatories is presented for purposes of additional analysis and is not a required part of the financial statements but is supplementary information required by the MIA. 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 financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the 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 financial statements as a whole.

KPMG LLP

McLean, Virginia
April 9, 2015

KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.

Statutory Statements of Admitted Assets, Liabilities, Capital, and Surplus

December 31, 2014 and 2013

(In thousands)

Admitted Assets	2014	2013
Cash and short-term investments	$ 101,946	$ 7,858
Premiums receivable - net	81,861	66,206
Health care receivables - net	26,276	49,472
Investment income due and accrued	891	867
Due from affiliated organizations	2,829	3,693
Receivables for securities	2,162	—
Amounts recoverable from reinsurers	3,165	—
Other receivables - net	136	—
Real estate properties occupied by Health Plan	588,591	593,848
Real estate properties held for the production of income	3,899	—
Property and equipment - net	142,366	164,606
Investments	242,279	234,311
Total admitted assets	$ 1,196,401	$ 1,120,861
Liabilities, Capital, and Surplus		
Liabilities:		
General expenses due or accrued	$ 41,510	$ 27,613
Reserves for unpaid claims and claims adjustment expense	95,111	78,296
Payroll liabilities	55,275	57,585
Payables for securities	3,161	—
Premiums received in advance	16,394	6,702
Ceded reinsurance premiums payable	1,162	—
Due to affiliated organizations - net	379,806	481,826
Due to associated medical group	9,453	18,032
Medicare payables and reserves	40,286	26,209
Long-term loan from affiliate and accrued interest	—	12,863
Pension and other retirement liabilities	333,263	174,425
Other liabilities	73,788	61,299
Total liabilities	1,049,209	944,850
Capital and surplus:		
Special surplus funds	24,000	—
Contributed capital	6,795	6,795
Surplus notes	264,000	133,000
Unassigned surplus (deficit)	(147,603)	36,216
Total capital and surplus	147,192	176,011
Total liabilities, capital, and surplus	$ 1,196,401	$ 1,120,861

See accompanying notes to statutory financial statements.

KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.

Statutory Statements of Revenues and Expenses

Years ended December 31, 2014 and 2013

(In thousands)

	2014	2013
Revenues:		
Net premium revenue	$ 2,277,563	$ 2,101,409
Medicare cost contract revenue	299,929	277,734
Other revenue	44,072	34,981
Total revenues	2,621,564	2,414,124
Medical and hospital expenses:		
Hospital and medical benefits	809,029	808,258
Other professional services	679,755	648,882
Emergency room and out-of-area	140,772	129,457
Other medical and hospital expenses	708,006	634,981
Net reinsurance recoveries	(5,461)	—
Total medical and hospital expenses	2,332,101	2,221,578
Claims adjustment expenses	52,172	139,895
General administrative expenses	243,339	68,849
Total expenses	2,627,612	2,430,322
Loss before other items	(6,048)	(16,198)
Net investment and other income (loss)	(1,588)	(2,811)
Recognized losses on investments and real estate - net	(4,700)	(369)
Statutory net loss	$ (12,336)	$ (19,378)

See accompanying notes to statutory financial statements.

KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.

Statutory Statements of Changes in Capital and Surplus

Years ended December 31, 2014 and 2013

(In thousands)

	2014	2013
Balance, beginning of year	$ 176,011	$ 182,339
Statutory net loss	(12,336)	(19,378)
Proceeds from surplus notes	131,000	—
Change in nonadmitted assets	(3,405)	3,042
Change in pension and other retirement liabilities	(144,067)	10,020
Change in net unrealized losses on investments	(11)	(12)
Balance, end of year	$ 147,192	$ 176,011

See accompanying notes to statutory financial statements.

KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.

Statutory Statements of Cash Flow

Years ended December 31, 2014 and 2013

(In thousands)

	2014	2013
Cash flows from operating activities:		
Premiums and revenues collected net of reinsurance	$ 2,570,289	$ 2,365,177
Miscellaneous income	66,476	16,630
Benefits and loss related payments	(2,278,700)	(2,180,550)
Commissions, expenses, and aggregate write-ins	(280,367)	(205,887)
Net investment income	31,654	27,246
Net cash provided from operating activities	109,352	22,616
Cash flows from investing activities:		
Purchase of real property	(36,230)	(106,163)
Proceeds from investments sold, matured, or repaid	140,850	176,111
Investment purchases	(149,188)	(175,151)
Receivables/payables for securities	999	(2,184)
Net cash used in investing activities	(43,569)	(107,387)
Cash flows from financing and miscellaneous sources:		
Change in long-term loan from affiliate and accrued interest	(12,863)	(331)
Proceeds from surplus notes	131,000	—
Increase in pension and other retirement liabilities	14,770	38,342
Net change in due from (due to) affiliated organizations	(101,156)	79,529
Other cash used	(3,446)	(67,132)
Net cash provided from financing and miscellaneous sources	28,305	50,408
Reconciliation of cash and short-term investments:		
Change in cash and short-term investments	94,088	(34,363)
Cash and short-term investments:		
Beginning of year	7,858	42,221
End of year	$ 101,946	$ 7,858
Supplemental cash flows disclosure:		
Cash paid for interest - net of capitalized amounts	$ 509	$ 1,257
Noncash investment transactions	$ 647	$ —

See accompanying notes to statutory financial statements.

(1) Description of Business

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Health Plan) is a not-for-profit corporation, generally exempt from federal and state income taxes, whose capital is available for charitable, educational, research, and related purposes. Health Plan is licensed by the States of Maryland and Virginia and the District of Columbia to provide prepaid health care services, which include health insurance. Health Plan is a subsidiary of Kaiser Foundation Health Plan, Inc. (KFHP). KFHP is affiliated with Kaiser Foundation Hospitals (Hospitals) because their governing boards and management are substantially the same.

The Mid-Atlantic Permanente Medical Group, P.C. (Medical Group) cooperates with Health Plan in conducting the Kaiser Permanente Medical Care Program. Health Plan contracts with Hospitals and the Medical Group to provide or arrange hospital and medical services for members. Contract payments to the Medical Group represent a substantial portion of the expenses for medical services reported in these statutory financial statements. Payments from Health Plan constitute substantially all of the revenues for the Medical Group. Because the Medical Group is independent and not controlled by Health Plan, its financial statements are not combined or consolidated with Health Plan.

At December 31, 2014 and 2013, the percentage of Health Plan's total labor force covered under collective bargaining agreements was approximately 81% and 79%, respectively.

Health Plan strives to improve the health and welfare of the communities it serves through its Direct Community Benefit Investment (DCBI) programs. DCBI expenditures provide funding for community benefit programs that serve communities through research, community-based health partnerships, direct health coverage for low-income families, and collaboration with community clinics, health departments, and public hospitals.

For the year ended December 31, 2014, DCBI expenditures (at cost, net of $21.3 million of DCBI related revenue) were $81.0 million, representing 3.1% of total revenue. In comparison, for the year ended December 31, 2013, DCBI expenditures (at cost, net of $3.3 million of DCBI related revenue) were $78.8 million, representing 3.3% of total revenue. The calculation of DCBI expenditures is based on Health Plan's direct and indirect costs and the services provided by Health Plan under DCBI programs.

(2) Summary of Significant Accounting Policies

(a) Accounting Practices

The statutory financial statements of Health Plan have been prepared in conformity with the National Association of Insurance Commissioners' (NAIC) Accounting Practices and Procedures Manual (NAIC SAP), the NAIC Annual Statement Instructions, and other accounting practices, as prescribed or permitted by the Maryland Insurance Administration (MIA). Management has evaluated subsequent events through April 9, 2015, which is the date that these financial statements were available to be issued.

The MIA recognizes only statutory accounting practices prescribed or permitted by the State of Maryland for determining and reporting the financial condition and results of operations of an insurance company for the purpose of determining its solvency under the Maryland Insurance Law.

NAIC SAP has been adopted as a component of prescribed or permitted practices by the State of Maryland.

In 2014, Health Plan changed the methodology to allocate expenses from claims adjustment expenses to general administrative. Management views this change in methodology to be a preferable method of presentation. Had this allocation method been used in 2013, general administrative expenses would have been $157.2 million and claims adjustment expenses would have been $51.6 million.

Statutory accounting practices prescribed and permitted by the State of Maryland vary from U.S. generally accepted accounting principles (GAAP) in the following respects: (1) certain assets designated as "nonadmitted," principally certain accounts receivable, property and equipment, prepaids, and other assets not specifically identified as an admitted asset within NAIC SAP are excluded from the accompanying statutory statements of admitted assets, liabilities, capital, and surplus and are charged directly to unassigned surplus (deficit); under GAAP, such assets are included in the balance sheet; (2) investments, other than investments in subsidiaries, are carried at values prescribed by the NAIC SAP; GAAP requires trading and available-for-sale investments held by a not-for-profit corporation, other than investments in subsidiaries, to be carried at fair value; (3) medical center furniture, fixtures, and equipment used in the direct delivery of care are depreciated over the lesser of their useful lives or three years; under GAAP, these assets are depreciated over their useful lives; (4) the statements of cash flows differ in certain respects from the presentation required by GAAP, including the presentation of changes in cash and short-term investments - net, instead of cash and cash equivalents; short-term investments include investments with maturities, at the time of acquisition, of one year or less; there is no reconciliation between net income and cash from operations for statutory purposes; (5) net negative cash balances are reported as a negative asset rather than as a liability under GAAP; (6) co-payments received are netted against hospital and medical benefit expenses; under GAAP, certain of these co-payments are recorded as revenues; (7) asset retirement obligations required under GAAP are not recorded; (8) the NAIC SAP requires health care service contractors to report rental income and expense on the occupancy of owned buildings; this is not reported under GAAP; (9) subordinated notes are classified as capital and surplus while GAAP requires classification as debt; (10) the unapproved interest on subordinated notes is accrued under GAAP and not accrued under statutory reporting; (11) Financial Accounting Standards Board Accounting Standards Update (ASU) 2010-24 *Health Care Entities (Topic 954): Presentation of Insurance Claims and Related Insurance Recoveries*, which requires insurance recoveries and liabilities to be reported gross, was adopted for GAAP as of January 1, 2011, but was rejected for statutory reporting in Issue Paper (IP) No. 99; (12) ASU 2011-07 *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities*, was adopted for GAAP as of January 1, 2012, but was rejected for statutory reporting in IP No. 99. ASU 2011-07 requires certain health care entities to present the provision for bad debts related to patient service revenue as a deduction from patient service revenue and provides enhanced disclosure regarding policies for recognizing revenue and assessing bad debt; (13) the NAIC SAP provides that the defined benefit pension and postretirement benefit liability calculations and expense may be recognized over a phase-in period for active participants not currently vested in the plans; GAAP requires the full liability and expense for these participants to be recorded; (14) reinsurance recoveries on unpaid claims and claim adjustment expense are netted against the

related reserves rather than as assets as required under GAAP; and (15) the Health Insurers Provider fee under the Patient Protection and Affordable Care Act (PPACA) is expensed immediately in January of the fee year; under GAAP, this cost is deferred and amortized during the course of the fee year. Reclassifications from unassigned surplus to special surplus funds are required in the year prior to the fee year (the data year) for the amount expected to be paid in the fee year; under GAAP, no such reclassification is required.

The following reconciles Health Plan's statutory net loss and statutory capital and surplus determined in accordance with accounting practices prescribed or permitted by the State of Maryland, with net income and net worth on a GAAP basis at December 31 (in thousands):

	2014	2013
GAAP net loss	$ (4,272)	$ (14,947)
Interest on surplus notes	4,545	4,004
Postretirement benefit liabilities	(3,502)	(2,856)
Depreciation	(3,610)	(5,207)
Asset retirement obligation	46	(109)
Impairment loss on real estate	(5,073)	—
Other	(470)	(263)
Statutory net loss	$ (12,336)	$ (19,378)
GAAP net deficit	$ (141,392)	$ (20,878)
Nonadmitted assets	(20,943)	(17,538)
Surplus notes	264,000	133,000
Interest on surplus notes	14,961	10,416
Pension and other postretirement liabilities	70,201	102,183
Unrealized gains on investments	(1,053)	(1,697)
Depreciation	(32,537)	(28,927)
Asset retirement obligation	1,498	1,452
Impairment loss on real estate	(5,073)	—
Other	(2,470)	(2,000)
Statutory capital and surplus	$ 147,192	$ 176,011

For the years ended December 31, 2014 and 2013, there were no significant differences between the NAIC SAP and the practices prescribed by or permitted by the State of Maryland that impacted the Health Plan's statutory net income or capital and surplus.

(b) Cash and Short-term Investments

Cash and short-term investments include interest-bearing deposits purchased with an original or remaining maturity of twelve months or less.

At December 31, cash and short-term investments were as follows (in thousands):

	2014	2013
Cash	$ 98,656	$ 794
Short-term investments	3,290	7,064
Cash and short-term investments	$ 101,946	$ 7,858

(c) Premiums and Health Care Receivables

Premiums and health care receivables - net exclude nonadmitted balances. Certain receivables are not admissible in accordance with the NAIC SAP. Nonadmitted amounts include all nongovernmental premiums and health care receivables greater than 90 days past due. In addition, when premiums and health care receivables greater than 90 days past due are more than a de minimus portion of the entire premiums and health care receivables balance, the entire premiums and health care receivables balance is nonadmitted.

(d) Real Estate, Property, and Equipment

Real estate, property, and equipment, which include land, buildings, equipment, and software, are stated at cost less accumulated depreciation and amortization. Interest is capitalized on facilities construction in progress and is added to the cost of the underlying asset. Depreciation begins when the project is substantially complete and ready for its intended use. Software is amortized on a straight-line basis over three years. Buildings and equipment are depreciated on a straight-line basis over the estimated useful lives of the various classes of assets, generally ranging from 3 to 33 years, except that medical center furniture, fixtures, and equipment used in the direct delivery of care are depreciated over their estimated useful lives but for a period not to exceed three years.

At December 31, 2014 and 2013, real estate, property, and equipment included in the statement of admitted assets, liabilities, capital, and surplus were net of encumbrances of $9.5 million and $19.8 million, respectively.

Management evaluates alternatives for delivering services that may affect the current and future utilization of existing and planned assets and could result in an adjustment to the carrying values or remaining lives of such land, buildings, equipment, and software in the future. Management evaluates and records impairment losses or adjusts remaining lives, where applicable, based on expected utilization, projected cash flows, and recoverable values.

Maintenance and repairs are expensed as incurred. Major improvements that increase the estimated useful life of an asset are capitalized. Upon the sale or retirement of assets, recorded cost and related accumulated depreciation are removed from the accounts, and any gain or loss on disposal is reflected in operations.

Included in property and equipment are health care delivery assets representing pharmaceutical and optical inventories, as well as medical center furniture, fixtures, and equipment used in the direct

delivery of care. Pharmaceutical and optical inventories are included in the furniture and equipment category. Pharmaceutical and optical inventories are not subject to depreciation.

(e) Investments

Investments include money market funds, U.S. Treasury and government-sponsored agencies, loan-backed and/or structured securities, industrial and miscellaneous bonds, and other government bonds. Recognized gains and losses are recorded on the specific identification basis. Interest income is included in net investment and other income.

Bonds are reported in accordance with NAIC Annual Statement Instructions (Statement Value). Accordingly, bonds that are designated highest quality, NAIC Designation 1 and 2, are reported at amortized cost using the effective-interest method, and bonds that are classified as NAIC Designation 3 or lower are reported at lower of amortized cost or fair value.

Adjustments are made prospectively and repayment assumptions are obtained from a third party vendor data source for loan-backed and/or structured securities. The amortization method used is the scientific method.

Investments are regularly reviewed for impairment and a charge is recognized when the fair value is below cost basis and is judged to be other-than-temporary. Impairment is included in recognized losses on investments and real estate - net. In its review of assets for impairment that is deemed other-than-temporary, management generally follows the following guidelines:

- Substantially all investments are managed by outside investment managers who do not need Health Plan's management preapproval for sales; therefore, substantially all declines in value below amortized cost are recognized as impairment that is other-than-temporary.
- For other securities, losses are recognized for known matters, such as bankruptcies, regardless of ownership period, and investments that have been continuously below book value for an extended period of time are evaluated for impairment that is other-than-temporary.

Health Plan's investment transactions are recorded on a trade date basis.

Health Plan is required to keep investments on deposit in the States of Maryland and Virginia and the District of Columbia, where it is licensed. At December 31, 2014 and 2013, $806 thousand and $809 thousand, respectively, in investments were restricted to satisfy the states' regulatory requirements.

(f) Reserves for Unpaid Claims and Claims Adjustment Expense

The cost of health care services is recognized in the period in which services are provided. Reserves for unpaid claims and claims adjustment expense consist of unpaid health care expenses to third party providers, which include an estimate of the cost of services provided to Health Plan's members by the third party providers that have been incurred but not reported. The estimate for incurred but not reported claims is based on actuarial projections of costs using historical paid claims and other relevant data. Estimates are monitored and reviewed and, as settlements are made or estimates are revised,

adjustments are reflected in current operations. Such estimates are subject to the impact of changes in the regulatory environment and economic conditions, actual utilization of medical services, changes in membership and product mix, claim submission and processing patterns, and other relevant factors. Given the inherent variability of such estimates, the actual liability could differ significantly from the amounts provided. While the ultimate amount of paid claims is dependent on future developments, management is of the opinion that the reserves for unpaid claims and claims adjustment expense are adequate to cover such claims.

Health Plan records anticipated reinsurance recoveries for high cost claims eligible for reimbursement under the PPACA as described in *The PPACA Reinsurance, Risk Adjustment, and Risk Corridors Programs* note. The amount recorded is an estimate as the ultimate adjudication of these claims will be conducted by the government, and the percentage of claims amounts eligible for reimbursement is permitted to vary from as much as 100% of the claims' value to some lesser amount, as determined.

(g) Receivables and Payables for Securities

Receivables and payables for securities represent current amounts for unsettled securities sales or purchases.

(h) Due to Associated Medical Group

Due to associated medical group consists primarily of unpaid medical expenses owed to the Medical Group for medical services provided to members under a medical services agreement with Health Plan. The cost of medical services is recognized by Health Plan in the period in which services are provided and is reflected as a component of medical and hospital services expenses.

(i) Insured and Self-Insured Risks

Health Plan purchases insurance including workers' compensation, professional, and general liabilities coverage. Certain insurance is purchased from affiliated organizations as discussed in the *Information Concerning Parent, Affiliated Organizations, and Medical Group* note. Health Plan self-insures other risks including other legal liabilities. Costs associated with self-insured risks are charged to operations based upon actual and estimated claims. Estimates are monitored and reviewed and, as settlements are made or estimates are revised, adjustments are reflected in current operations. Given the inherent variability of such estimates, the actual liability could differ significantly from the amounts provided. While the ultimate payments for self-insured claims are dependent on future developments, management is of the opinion that the reserve for self-insured risks is adequate.

(j) Premium Deficiency Reserves

Premium deficiency reserves and the related expense are recognized when it is probable that expected future health care and maintenance costs under a group of existing contracts will exceed anticipated future premiums and reinsurance recoveries over the contract period. Expected investment income and interest expense are included in the calculation of premium deficiency reserves, as appropriate. The level at which contracts are grouped for evaluation purposes is generally at the regional level. The methods for making such estimates and for establishing the resulting reserves are reviewed and updated, and any resulting adjustments are reflected in current operations. At December 31, 2014 and

2013, the need for premium deficiency reserves was assessed and management is of the opinion that no premium deficiency reserves were required. Given the inherent variability of such estimates, the actual liability could differ significantly from the calculated amount.

(k) Revenue Recognition

Net premium revenue includes premiums from employer groups, individuals, and Medicare. Net premium revenue is recognized over the period in which the members are entitled to health care services.

Health Plan estimates accrued retrospective premium adjustments for certain group health insurance contracts based on claims experience and the provisions of the contract. Health Plan records accrued retrospective premiums as an adjustment to earned premiums. For the years ended December 31, 2014 and 2013, the amount of premiums written by Health Plan subject to the retrospective rating feature were $52.1 million and $59.7 million, respectively. During 2014 and 2013, revenue derived under these contracts was 2.0% and 2.5%, respectively, of total premiums written. During 2014 and 2013, retrospective premium adjustments under these contracts were $(1.9) million and $1.4 million, respectively.

The majority of Health Plan's Medicare revenue is paid based on cost, with interim payments using pre-established rates, and the final settlement is made after the end of the year. Estimates of final settlements of the Medicare cost report are recorded by Health Plan. At December 31, 2014 and 2013, in connection with Health Plan's Medicare cost contract, Health Plan recorded allowances and reserves for adjustments of recorded revenues in the amount of $33.5 million and $52.6 million, respectively. For the years ended December 31, 2014 and 2013, Medicare revenues increased approximately $14.6 million and $21.0 million, respectively, due to prior year retrospective adjustments in excess of amounts previously estimated.

In addition, Medicare benefits include a voluntary prescription drug benefit (Part D). Revenues for Part D include capitated payments made from Medicare adjusted for health risk factor scores. Revenues also include amounts to reflect a portion of the health care costs for low-income Medicare beneficiaries and a risk-sharing arrangement to limit the exposure to unexpected expenses. Related accruals are recognized monthly based on cumulative experience and membership data. Part D revenue is finalized after all data is submitted to Medicare and the final settlement is made after the end of the year.

Medicare Cost revenue and Medicare Part D revenue are subject to governmental audits and potential payment adjustments. The Centers for Medicare & Medicaid Services (CMS) performs coding audits to validate the supporting documentation maintained by Health Plan and its care providers.

Estimates of retrospective adjustments resulting from coding audits, cost reports, and other contractual adjustments are recorded in the time period in which members are entitled to health care services. Actual retrospective adjustments may differ from initial estimates.

Premiums collected in advance are deferred and recorded as premiums received in advance or Medicare payments received in advance. Revenue is adjusted to reflect estimates of collectability,

including retrospective membership adjustment trends and economic conditions. Revenue and related receivables are exclusive of charity care. A portion of revenues derived under contracts with the United States Office of Personnel Management (USOPM) is subject to audit and potential retrospective adjustments. Revenue derived under contracts with the USOPM in 2014 and 2013 were 27.3% and 27.9%, respectively, of total revenue.

In July 2014, conflicting federal judicial opinions were issued in two jurisdictions regarding the issue of whether or not individuals enrolled in the federal exchange are eligible for subsidies under the PPACA. A panel of the U.S. Court of Appeals of the District of Columbia ruled that the PPACA only provides for premium subsidies for enrollees on state exchanges. A panel of the U.S. Court of Appeals for the Fourth Circuit ruled oppositely that such subsidies are consistent with PPACA language. Resolution of this legal matter is, therefore, pending. For the year ended December 31, 2014, Health Plan had recorded $31.9 million in PPACA subsidies related to individuals enrolled on the federal exchange.

(l) Pension and Other Postretirement Benefits

Health Plan participates in defined benefit pension and other postretirement benefit plans that are administered by KFHP. The plans are actuarially evaluated and involve various assumptions. Critical assumptions include the discount rate and the expected rate of return on plan assets, and the rate of increase for health care costs (for postretirement benefit plans other than pension), which are important elements of expense and/or liability measurement. Other assumptions involve demographic factors such as retirement age, mortality, turnover, and the rate of compensation increases. KFHP evaluates assumptions annually, or when significant plan amendments occur, and modifies them as appropriate. Pension and postretirement costs are allocated over the service period of the employees in the plans.

KFHP uses a discount rate to determine the present value of the future benefit obligations. The discount rate is established based on rates available for high-quality fixed-income debt securities at the measurement date whose maturity dates match the expected cash flows of the retirement plans.

Differences between actual and expected plan experience and changes in actuarial assumptions, in excess of a 10% corridor around the larger of plan assets or plan liabilities, are recognized into benefits expense over the expected average future service of active participants. Prior service costs and credits arise from plan amendments and are amortized into postretirement benefits expense over the expected average future service to full eligibility of active participants.

The defined benefit pension plan administered by KFHP constitutes a single plan in which multiple employers who are related parties participate. The Employee Retirement Income Security Act provides for joint and several liability for all employers in the Health Plan's tax controlled group. The pension liability for Health Plan represents the estimated amount of liability for current and former employees of Health Plan only. Management believes it is remote that Health Plan would be required to pay benefits attributable to current or former employees of other controlled group members.

The other postretirement benefits (primarily health care) are generally offered through two welfare plans (Health and Welfare Plans) in which multiple employers who are related parties participate. Under the terms of the Health and Welfare Plans, each participating employer is legally liable for the

benefits for their own employees and retirees, and the Employee Retirement Income Security Act does not specify joint and several liability for all employers participating in a welfare plan. Management believes it is remote that Health Plan would be required to pay benefits attributable to current or former employees of any other employers participating in the Health and Welfare Plans.

(m) Donations and Grants Made or Received

Donations and grants made are recognized at fair value in the period in which a commitment is made, provided the payment of the donation or grant is probable and the amount is determinable. Donations or grants received are recognized at fair value in the period the donation or grant was committed unconditionally by the grantor or in the period the donation or grant requirements are met, if later.

(n) Guarantee Fund and Other Assessments

Health Plan participates in the Commonwealth of Virginia Birth-Related Neurological Injury Compensation Fund. This fund is designed to provide obstetrical care for patients eligible for Medical Assistance services. There was no liability at December 31, 2014 and 2013.

Health Plan is annually required to support the operations of the Departments of Insurance for Maryland, Virginia, and the District of Columbia through an administrative expenses assessment. There was no liability at December 31, 2014 and 2013.

The PPACA imposes a new Health Insurance Providers (HIP) fee. Current guidance provides that the HIP fee will be assessed at the KFHP control group level by the Internal Revenue Service (IRS) annually. The IRS assessment for 2015 and 2014 is based on the agency's calculation of the KFHP group's net premiums in the data years of 2014 and 2013, respectively, as a percentage of the total premiums for all U.S. health plans in the data year. Management determined that the 2014 assessment on Health Plan was $16.0 million and recorded the estimate of the annual assessment in January 2014. The total amount assessed to the KFHP group was paid in September 2014. Management has estimated the 2015 assessment on Health Plan to be approximately $24.0 million and will record the annual assessment in January 2015. The 2015 assessment has been segregated and classified as special surplus funds in capital and surplus. Had such assessment been recorded as of December 31, 2014, the amount disclosed in the *Minimum Capital and Surplus* note for the amount by which Health Plan's regulatory capital and surplus exceeded the authorized control level would have been lower by $24.0 million. A risk based capital (RBC) action level would not have been triggered had the 2015 fee been recorded as of December 31, 2014.

For the years ended December 31, 2014 and 2013, PPACA related amounts were as follows (in thousands):

	2014	2013
PPACA fee assessment payable for the upcoming year	$ 24,000	$ 16,000
PPACA fee assessment paid	17,430	—
Premiums written subject to PPACA assessment	2,578,741	2,370,366
Total Adjusted Capital before surplus adjustment	147,192	
Authorized Control Level before surplus adjustment	53,728	
Total Adjusted Capital after surplus adjustment	123,192	
Authorized Control Level after surplus adjustment	53,728	

(o) Use of Estimates in the Preparation of the Financial Statements

The preparation of the statutory financial statements in conformity with NAIC SAP, the NAIC Annual Statement Instructions, and other accounting practices as prescribed or permitted by the MIA requires management to make estimates and assumptions that affect the reported amounts. Allowance for uncollectible premiums and health care receivables; estimated fair value of investments; Medicare revenue accruals; Medicare payables and reserves; reserves for unpaid claims and claims adjustment expense; pension and other retirement liabilities; self-insured other legal liabilities; real estate, property, equipment, and software impairment and useful lives; investment impairment; and amounts accrued related to the PPACA Reinsurance Program represent significant estimates. Actual results could differ materially from those estimates. With respect to employee benefit plans, as occurs from time to time, negotiations with labor partners may result in changes to compensation and benefits. These changes are reflected in the statutory financial statements as appropriate when agreements are finalized.

(p) The PPACA Reinsurance, Risk Adjustment, and Risk Corridors Programs

The PPACA includes three programs designed to mitigate health plan risk. Two are temporary and one is permanent.

The Reinsurance Program provides for partial reimbursement of certain high cost claims for non-grandfathered individual members, beginning in 2014 and continuing through 2016. As described in the *Reserves for Unpaid Claims and Claims Adjustment Expense* note, certain amounts have been recorded in 2014 as expected claims reimbursements under this program. Regulations provide that claims for 2014 will be submitted beginning in 2014 and continuing through April 2015. For the year ended December 31, 2014, Health Plan has recorded $5.5 million for estimated recoveries from the Reinsurance Program.

The Risk Adjustment Program is permanent, and provides for retrospective adjustment of revenue for non-grandfathered individual and small group market plans, whether inside or outside PPACA exchanges. All participating insurers will begin submitting data on risk indicators for these populations

by April 2015 and will subsequently be notified in 2015 of any revenue adjustments related to 2014 business. The Risk Adjustment Program is designed such that payments to plans with higher relative risk are funded by transfers from plans with lower relative risk. Management cannot reasonably estimate adjustments related to this program, absent information on the risk factors of competitors' enrolled non-grandfathered individual and small group market plans and, accordingly, no adjustments to revenue have been recorded for the year ended December 31, 2014.

The Risk Corridors Program is temporary for the years 2014 - 2016. This program provides for gains and losses on the individual and small group market plans to be shared with the government. The Risk Corridors Program calculation is scheduled to be submitted to the government in conjunction with the Medical Loss Ratio filings in 2015, for 2014 business, as required by the PPACA. Revenue adjustments and claims expense adjustments relating to the Risk Adjustment Program and the Reinsurance Program are necessary to perform this calculation for 2014 business. Therefore, management has recorded no revenue adjustment amounts related to the Risk Corridors Program for the year ended December 31, 2014.

Health Plan is required to pay an annual assessment under the District of Columbia Health Benefit Exchange Authority Financial Sustainability Amendment Act of 2014. The 2014 assessment was $3.3 million and was based on 1% of 2013 gross premiums originating from the District of Columbia.

(q) New Accounting Pronouncements

In February 2014, the NAIC adopted revisions to SSAP No. 35R, *Guaranty Fund and Other Assessments* and later modified and adopted in 2014 as SSAP No. 106, *Affordable Care Act Assessments*. This guidance was adopted by Health Plan in 2014. This accounting standard is applicable to the HIP fee provided for in the PPACA. The standard requires that the liability and the related expense for the annual HIP fee is recorded on January 1 of the year when the fee is paid (Fee Year). The standard also requires classification of amounts in special surplus funds at December 31 of the Data Year (the year that the premiums used to allocate the fee are written) and additional disclosures of total adjusted capital and authorized control level and what those amounts would have been if the Health Plan had recorded the fee as a liability at December 31 of the Data Year. Management has recorded these amounts in the financial statements and required disclosures have been included in the *Guarantee Fund and Other Assessments* note.

In December 2014, the NAIC adopted SSAP No. 107, *Accounting for the Risk-Sharing Provisions of the Affordable Care Act*. This guidance was adopted by Health Plan in 2014. This accounting standard provides accounting for three programs of the PPACA including Risk Adjustment, Reinsurance, and Risk Corridors. The standard also requires disclosures of the assets, liabilities, and revenue balances for each of the three programs including a roll-forward of prior year amounts and reasons for adjustments to prior year balances. Management has recorded risk-sharing amounts in the financial statements and the required disclosures have been included in the *Risk-Sharing Provisions of the Affordable Care Act* note.

(3) Fair Value Estimates

The carrying amounts reported in the statutory statements of admitted assets, liabilities, capital, and surplus for cash (overdraft) and short-term investments - net, premiums receivable - net, health care receivables - net, due from affiliated organizations, receivables for securities, amounts recoverable from reinsurers, general expenses due or accrued, reserves for unpaid claims and claims adjustment expense, payroll liabilities, payables for securities, premiums received in advance, due to affiliated organizations, due to associated medical group, long-term loan from affiliate, ceded reinsurance premiums payable, and PPACA taxes included in other liabilities approximate fair value.

Investments, as discussed in the *Investments* note, are reported at lower of amortized cost or fair value, with impairment recorded if amortized cost is greater than fair value. The fair values of investments are based on quoted market prices, if available, or estimated using quoted market prices for similar investments. If listed prices or quotes are not available, fair value is based upon other observable inputs or models that primarily use market-based or independently sourced market parameters as inputs. In addition to market information, models also incorporate transaction details such as maturity. Fair value adjustments, including credit, liquidity, and other factors, are included, as appropriate, to arrive at a fair value measurement.

Health Plan utilizes a three-level valuation hierarchy for fair value measurements. An instrument's categorization within the hierarchy is based upon the lowest level of input that is significant to the fair value measurement. For instruments classified in level 1 of the hierarchy, valuation inputs are quoted prices for identical instruments in active markets at the measurement date. For instruments classified in level 2 of the hierarchy, valuation inputs are directly observable but do not qualify as level 1 inputs. Examples of level 2 inputs include: quoted prices for similar instruments in active markets; quoted prices for identical or similar instruments in inactive markets; other observable inputs such as interest rates and yield curves observable at commonly quoted intervals, volatilities, prepayment speeds, loss severities, credit risks, and default rates; and market-correlated inputs that are derived principally from or corroborated by observable market data. For instruments classified in level 3 of the hierarchy, valuation inputs are unobservable inputs for the instrument. Level 3 inputs incorporate assumptions about the factors that market participants would use in pricing the instrument.

(4) Information Concerning Parent, Affiliated Organizations, and Medical Group

Health Plan contracts with Hospitals and the Medical Group to provide or arrange hospital and medical services for members. During 2014 and 2013, based upon the terms of the Hospital Service Agreement, Health Plan was charged $314.7 million and $295.1 million, respectively, by Hospitals. During 2014 and 2013, based upon the terms of the agreement with the Medical Group, Health Plan incurred expenses of $517.7 million and $489.7 million, respectively.

Costs of services provided by KFHP and Hospitals to Health Plan were based on the actual cost incurred to provide those services. Services provided include, but are not limited to, the following: information technology, treasury, general management, administrative support, and transaction processing. Additionally, Health Plan was charged for any amounts paid by KFHP or Hospitals on Health Plan's behalf. During 2014 and 2013, charges for costs of services provided by KFHP and Hospitals, and for amounts paid by KFHP and Hospitals on behalf of Health Plan, were $1.3 billion and $1.5 billion, respectively. During 2014 and

2013, Health Plan was charged interest expense of $5.6 million and $6.6 million, respectively, by KFHP and Hospitals, including long-term loan from affiliate.

Health Plan purchases professional liability and other insurance from affiliated organizations, primarily Lokahi Assurance, Ltd. During 2014 and 2013, Health Plan's premium expense under these arrangements was $20.9 million and $23.2 million, respectively.

Health Plan contracts with Kaiser Permanente Insurance Company (KPIC), a subsidiary of KFHP, to provide administrative services including, but not limited to, product development, rating and underwriting, marketing and sales, advertising, claims adjudication, member services, utilization management, and premium billing and collection. For the years ended December 31, 2014 and 2013, pursuant to this contract, Health Plan recognized revenues of $3.7 million and $3.6 million, respectively. In addition, Health Plan and KPIC cooperate in the delivery of services under Point of Service products. Under this arrangement, premiums from customers are allocated between Health Plan and KPIC based on prospective estimates of utilization. During 2014 and 2013, pursuant to this arrangement, Health Plan recognized $25.0 million and $45.7 million, respectively, in premium revenue under these Point of Service products.

Health Plan has also entered into reciprocal business relationships with KFHP whereby Health Plan and KFHP and its subsidiaries provided medical services to visiting members. At both 2014 and 2013, net revenue recorded for services provided by Health Plan was $7.8 million. During 2014 and 2013, net expense for services provided to Health Plan members was $7.2 million and $5.8 million, respectively.

Health Plan has a guaranty agreement with the parent, KFHP, and affiliates in which the parent and Hospitals, without exception, guarantee all obligations of Health Plan, including a guarantee to provide health care services to Health Plan's subscribers, enrollees, and dependents in the event that Health Plan is discontinued prior to the expiration of Health Plan's contracts. In addition, Hospitals has loaned certain subordinated debt to Health Plan as described in the *Minimum Capital and Surplus* note.

Health Plan participated in an *Investment Account Participation Agreement* with Hospitals, KFHP, and another KFHP subsidiary until it was terminated on January 31, 2014.

At December 31, due to affiliated organizations - net, was as follows (in thousands):

	2014	2013
Net amounts due from (due to):		
Kaiser Foundation Health Plan, Inc.	$ (19,229)	$ (20,045)
Kaiser Foundation Hospitals	(359,939)	(461,008)
Other affiliated organizations	2,191	2,920
Total due to affiliated organizations - net	$ (376,977)	$ (478,133)
Amount due from (due to):		
Due from affiliated organizations	$ 2,829	$ 3,693
Due to affiliated organizations	(379,806)	(481,826)
Total due to affiliated organizations - net	$ (376,977)	$ (478,133)

The long-term loan from affiliate and accrued interest was $12.9 million at December 31, 2013, with a due date of July 1, 2015 and interest payable semi-annually at a rate of 5.375%. The loan was repaid on October 1, 2014.

Due to Hospitals generally represents funds owed to Hospitals by Health Plan to satisfy Health Plan's operational requirements and amounts due to Hospitals for claims of $51.9 million and $38.9 million at December 31, 2014 and 2013, respectively. These amounts are not included in due to affiliated organizations, but are included in reserves for unpaid claims and claims adjustment expense, per instruction by the Maryland Insurance Administration. Hospitals' claims expense is included in Health Plan's operating expenses, primarily hospital services.

(5) Health Care Receivables - net

Health care receivables consist primarily of Medicare cost contract, Medicare Part D, fee-for-service, and pharmaceutical rebates.

In 2013, KFHP transferred the pharmaceutical rebate receivable to Health Plan. Health Plan records an estimated receivable until rebates are actually invoiced within two months after the end of the quarter. Pharmacy rebate receivables are estimated based on actual prescriptions filled and sold during the quarter, and rebates actually invoiced within the two months following the end of the quarter. Rebates receivable were $5.7 million and $1.7 million at December 31, 2014 and 2013, respectively. Rebates receivable are nonadmitted if they are outstanding longer than 90 days since the invoice date. Amounts invoiced or confirmed and their related aging may be updated due to activity in subsequent periods.

The pharmaceutical rebates are summarized as follows (in thousands):

Quarter ending	Estimated	Invoiced or confirmed	Collected within 90 days	Collected within 90 to 180 days	Collected within more than 180 days
3/31/2014	$ 4,612	$ 4,449	$ 3,515	$ —	$ —
6/30/2014	4,954	4,980	3,958	—	—
9/30/2014	5,489	7,061	3,447	—	—
12/31/2014	5,944	4,203	3,049	—	—

Quarter ending	Estimated	Invoiced or confirmed	Collected within 90 days	Collected within 90 to 180 days	Collected within more than 180 days
3/31/2013	$ —	$ —	$ —	$ —	$ —
6/30/2013	1,166	1,166	1,183	—	—
9/30/2013	1,442	1,442	1,237	—	—
12/31/2013	1,494	1,494	1,395	303	—

(6) Real Estate, Property, and Equipment - net

At December 31, 2014, real estate, property, and equipment - net were as follows (in thousands):

	Real estate properties occupied by Health Plan	Real estate properties held for the production of income	Property and equipment - net: Furniture and equipment	Leasehold improvements	Computer equipment	Total
Cost	$ 879,679	$ 5,767	$ 256,985	$ 149,311	$ 13,966	$ 420,262
Amount classified as nonadmitted	(9,530)	—	(636)	(1,001)	(286)	(1,923)
	870,149	5,767	256,349	148,310	13,680	418,339
Accumulated depreciation and amortization	(281,558)	(1,868)	(186,195)	(77,750)	(12,028)	(275,973)
Total	$ 588,591	$ 3,899	$ 70,154	$ 70,560	$ 1,652	$ 142,366

For the year ended December 31, 2014, depreciation and amortization expense was as follows (in thousands):

	Real estate properties occupied by Health Plan	Real estate properties held for the production of income	Property and equipment - net: Furniture and equipment	Leasehold improvements	Computer equipment	Total
Depreciation and amortization expense	$ 32,534	$ —	$ 30,378	$ 9,157	$ 2,414	$ 41,949

At December 31, 2013, real estate, property, and equipment - net were as follows (in thousands):

	Real estate properties occupied by Health Plan	Property and equipment - net: Furniture and equipment	Leasehold improvements	Computer equipment	Total
Cost	$ 854,195	$ 246,263	$ 146,612	$ 13,468	$ 406,343
Amount classified as nonadmitted	(9,549)	(891)	(1,439)	(517)	(2,847)
	844,646	245,372	145,173	12,951	403,496
Accumulated depreciation and amortization	(250,798)	(159,955)	(69,320)	(9,615)	(238,890)
Total	$ 593,848	$ 85,417	$ 75,853	$ 3,336	$ 164,606

For the year ended December 31, 2013, depreciation and amortization expense was as follows (in thousands):

	Real estate properties occupied by Health Plan	Property and equipment - net			
		Furniture and equipment	Leasehold improvements	Computer equipment	Total
Depreciation and amortization expense	$ 29,026	$ 31,945	$ 12,024	$ 2,534	$ 46,503

For the years ended December 31, 2014 and 2013, impairment losses of real estate properties occupied by Health Plan totaled $5.1 million and $0, respectively. The impairment losses are included in recognized losses from investments and real estate - net in the statutory statements of revenue and expenses.

(7) Investments

Management's methods for estimating fair value of financial instruments are discussed in the *Fair Value Estimates* note.

At December 31, short-term investments, bonds, and other invested assets at statement value and estimated fair value, derived using level 2 inputs, were as follows (in thousands):

2014	Aggregate fair value	Statement value	Fair value in excess of carrying value
Short-term investments:			
Money market mutual funds	$ 3,290	$ 3,290	$ —
Total short-term investments	3,290	3,290	—
Bonds and other invested assets:			
U.S. Treasury and government-sponsored agencies	98,223	98,012	211
All other government bonds	2,209	2,201	8
Loan-backed and/or structured securities	46,497	46,306	191
Industrial and miscellaneous bonds	96,403	95,760	643
Total bonds and other invested assets	243,332	242,279	1,053
Total investments	$ 246,622	$ 245,569	$ 1,053

2013	Aggregate fair value	Statement value	Fair value in excess of carrying value
Short-term investments:			
Money market mutual funds	$ 7,064	$ 7,064	$ —
Total short-term investments	7,064	7,064	—
Bonds and other invested assets:			
U.S. Treasury and government-sponsored agencies	102,115	101,856	259
All other government bonds	4,034	3,994	40
Loan-backed and/or structured securities	43,554	43,288	266
Industrial and miscellaneous bonds	86,305	85,173	1,132
Total bonds and other invested assets	236,008	234,311	1,697
Total investments	$ 243,072	$ 241,375	$ 1,697

Investments are measured at fair value on a recurring basis. This includes securities reported at the lower of cost or fair value based on NAIC designation regardless of whether the security was reported in the previous period at amortized cost.

During 2014, the aggregate other-than-temporary impairment (OTTI) recognized for certain loan-backed and/or structured securities, by quarter of the calendar year, was as follows (in thousands):

Classifications	Amortized cost before OTTI	Recognized OTTI	Fair value
Inability or lack of intent to retain - Q1	$ 4,494	$ (12)	$ 4,482
Inability or lack of intent to retain - Q2	1,401	(3)	1,398
Inability or lack of intent to retain - Q3	15,655	(45)	15,610
Inability or lack of intent to retain - Q4	20,122	(32)	20,090
Total	$ 41,672	$ (92)	$ 41,580

Each impairment of loan-backed and/or structured securities recognized during the year ended December 31, 2014 was as follows (in thousands):

CUSIP	Security description	Amortized cost before OTTI	Present value of projected cash flow	Recognized OTTI	Amortized cost after latest OTTI	Fair value at impairment date	Current period final NAIC designation	Quarter impaired
05947U4D7	Bank of America Commercial Mtg	$ 1,256	$ 1,255	$ (1)	$ 1,255	$ 1,255	1FM	Q4 2014
06742LAG8	Barclays Dryrock Issuance Trust	919	916	(3)	916	916	1FE	Q4 2014
12513EAG9	Citigroup/Deutsche Bank Comm	1,001	999	(2)	999	999	1FM	Q4 2014
3137AGBN9	Freddie Mac	243	242	(1)	242	242	1	Q4 2014
3137AGE89	Freddie Mac	234	233	(1)	233	233	1	Q4 2014
3137B9SJ5	Freddie Mac	536	534	(2)	534	534	1	Q4 2014
3137BDY67	FHLMC Multifamily Structured P	320	318	(2)	318	318	1	Q4 2014
44890VAC6	Hyundai Auto Lease Securitization	1,085	1,083	(2)	1,083	1,083	1FE	Q4 2014
46625YSG9	JP Morgan Chase Commercial Mortgage	201	200	(1)	200	200	1FM	Q4 2014
46625YXP3	JP Morgan Chase Commercial Mortgage	280	279	(1)	279	279	1FM	Q4 2014
59022HMU3	Merrill Lynch Mortgage Trust	584	583	(1)	583	583	1FM	Q4 2014
03065JAD6	Americredit Automobile Receivables	326	325	(1)	325	325	1FE	Q4 2014
12558GAB1	CIT Equipment Collateral	771	770	(1)	770	770	1FE	Q4 2014
12630DAU8	Comm Mortgage Trust	776	775	(1)	775	775	1FM	Q4 2014
12632XAC2	CNH Equipment Trust	689	686	(3)	686	686	1FE	Q4 2014
228819AA6	Crusade Global Trust	481	480	(1)	480	480	1FE	Q4 2014
361894AE8	GM Financial Automobile Leasing	675	674	(1)	674	674	1FE	Q4 2014
38378BR27	Government National Mortgage	666	665	(1)	665	665	1	Q4 2014
38378BWG0	Government National Mortgage	880	879	(1)	879	879	1	Q4 2014
65490BAE5	Nissan Auto Lease Trust	860	859	(1)	859	859	1FE	Q4 2014
80284AAF3	Santander Drive Auto Receivable	735	733	(2)	733	733	1FE	Q4 2014
05947U2R8	Bank of America Commercial Mtg	687	685	(2)	685	685	1FM	Q3 2014
12513EAG9	Citigroup/Deutsche Bank Comm	1,029	1,026	(3)	1,026	1,026	1FM	Q3 2014
126171AF4	Commercial Mortgage Pass-Through	661	658	(3)	658	658	1FM	Q3 2014
12626GAA1	Commercial Mortgage Pass-Through	565	564	(1)	564	564	1FM	Q3 2014
12630DAU8	Comm Mortgage Trust	816	814	(2)	814	814	1FM	Q3 2014
17305EFE0	Citibank Credit Card Issuance	993	992	(1)	992	992	1FE	Q3 2014
3136AFQ80	Freddie Mac	1,087	1,086	(1)	1,086	1,086	1	Q3 2014
3136AGLH3	Freddie Mac	462	459	(3)	459	459	1	Q3 2014

CUSIP	Security description	Amortized cost before OTTI	Present value of projected cash flow	Recognized OTTI	Amortized cost after latest OTTI	Fair value at impairment date	Current period final NAIC designation	Quarter impaired
3136AKJ38	Fannie Mae	$ 690	$ 685	$ (5)	$ 685	$ 685	1	Q3 2014
3137BDY67	FHLMC Multifamily Structured	735	728	(7)	728	728	1	Q3 2014
38378BR27	Government National Mortgage	673	671	(2)	671	671	1	Q3 2014
38378BWG0	Government National Mortgage	918	913	(5)	913	913	1	Q3 2014
38378BXQ7	Government National Mortgage	656	654	(2)	654	654	1	Q3 2014
46625YXP3	JP Morgan Chase Commercial Mor	303	302	(1)	302	302	1FM	Q3 2014
46641BAA1	JP Morgan Chase Commercial Mor	615	614	(1)	614	614	1FM	Q3 2014
46641WAS6	JPMBB Commercial Mortgage Security	583	580	(3)	580	580	1FM	Q3 2014
65477NAD8	Nissan Auto Lease Trust	1,300	1,299	(1)	1,299	1,299	1FE	Q3 2014
65477PAC5	Nissan Auto Receivables Owner	1,397	1,396	(1)	1,396	1,396	1FE	Q3 2014
3136AGLH3	Fannie Mae	484	482	(2)	482	482	1	Q2 2014
17305EFC4	Citibank Credit Card Issuance	514	512	(2)	512	512	1FE	Q1 2014
3136AGKU5	Fannie Mae	627	623	(4)	623	623	1	Q1 2014
65477PAC5	Nissan Auto Receivables Owner	1,400	1,397	(3)	1,397	1,397	1FE	Q1 2014
38378BWG0	Government National Mortgage	950	948	(2)	948	948	1	Q1 2014
61763BAQ7	Morgan Stanley BAML Trust	478	477	(1)	477	477	1FM	Q1 2014
46625YGP2	JP Morgan Chase Commercial Mortgage	205	204	(1)	204	204	N/A	Q2 2014
Various	Securities with OTTI <$(1) (19 securities)	9,326	9,323	(3)	9,323	9,323	Various	Various

At December 31, 2014, no investments were owned by Health Plan pursuant to the *Investment Account Participation Agreement*. At December 31, 2013, a total of $95.5 million, of which $32.4 million was included in U.S. Treasury and government-sponsored agencies and $63.1 million was included in other debt instruments, primarily industrial and miscellaneous bonds, was owned by Health Plan pursuant to the *Investment Account Participation Agreement*.

The statement value and estimated fair value of bonds and short-term investments at December 31 are shown below by maturity (in thousands):

	2014		2013	
	Statement value	Estimated fair value	Statement value	Estimated fair value
Due in one year or less	$ 17,412	$ 17,457	$ 17,133	$ 17,182
Due after one year through five years	180,091	180,901	180,040	181,421
Due after five years through ten years	1,760	1,767	914	915
Loan-backed and/or structured securities	46,306	46,497	43,288	43,554
	$ 245,569	$ 246,622	$ 241,375	$ 243,072

Actual maturities will differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties.

For the years ended December 31, net investment and other income (in thousands) were comprised of the following (amounts included allocations from Hospitals):

	2014	2013
Interest and other investment income	$ 53,509	$ 46,373
Interest and other investment expense	(55,097)	(49,184)
Total net investment and other income	$ (1,588)	$ (2,811)

For the years ended December 31, 2014 and 2013, Health Plan recorded impairment of certain investments in accordance with the policy described in the *Summary of Significant Accounting Policies - Investments* note. For the years ended December 31, 2014 and 2013, the OTTI totaled $426 thousand and $1.4 million, respectively.

For the years ended December 31, 2014 and 2013, rental income related to administrative and health delivery owned buildings was $50.2 million and $43.0 million, respectively. These amounts are reflected as interest and other investment income in the above table.

During 2014, Health Plan sold, redeemed, or otherwise disposed of short and long-term investments for $245.0 million and realized gross gains of $803 thousand and gross losses of $3 thousand. During 2013, Health Plan sold, redeemed, or otherwise disposed of short and long-term investments for $297.7 million and realized gross gains of $1.0 million and gross losses of $23 thousand.

(8) Reserves for Unpaid Claims and Claims Adjustment Expense

Unpaid claims and claims adjustment expense includes both reported and unreported medical claims, which have been partially reduced by estimated recoverables for salvage and subrogation and estimated reinsurance recoveries under the PPACA. Unpaid claims incurred but not reported represent an estimate of claims incurred for or on behalf of Health Plan's members that had not yet been reported to the Health Plan in the statutory statements of admitted assets, liabilities, capital, and surplus. Unpaid claims are based on a number of factors including hospital admission data and prior claims experience, as well as claims processing patterns; adjustments, if necessary, are made to medical expense in the period the actual claims costs are ultimately determined. At December 31, 2014 and 2013, the estimated salvage and subrogation included as a reduction to unpaid claims and claims adjustment expense was $339 thousand and $2.3 million, respectively. At December 31, 2014, the estimated reinsurance recoveries under the PPACA included as a reduction to reserves for unpaid claims and claims adjustment expense was $2.3 million.

Claims adjustment expense represents costs incurred related to the claim settlement process such as costs to record, process, and adjust claims. These expenses are calculated using a percentage of current medical costs, which is based on historical cost experience.

For the years ended December 31, activity in the reserves for unpaid claims and claims adjustment expense was as follows (in thousands):

	2014	2013
Balances at January 1	$ 78,296	$ 82,395
Incurred related to:		
Current year	2,339,486	2,233,549
Prior years	(7,385)	(11,971)
Total incurred	2,332,101	2,221,578
Paid related to:		
Current year	2,246,459	2,157,112
Prior years	68,827	68,565
Total paid	2,315,286	2,225,677
Balances at December 31	$ 95,111	$ 78,296

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately adjudicated and paid. Liabilities are reviewed and revised as information regarding actual claims payments becomes known. Negative amounts reported for incurred related to prior years result from claims being adjudicated and paid for amounts less than originally estimated.

(9) Pension Plans

(a) Defined Benefit Plan

Health Plan participates with affiliated organizations in a defined benefit pension plan (Plan) covering substantially all its employees. Benefits are based on age at retirement, years of credited service, and average compensation for a specified period prior to retirement. Contributions are intended to provide not only for benefits attributed to service to date but also for those expected to be earned in the future.

For financial reporting purposes, the projected unit credit method is used. At December 31, 2014 and 2013, substantially all pension fund assets were held in a group trust. At December 31, 2014 and 2013, the trust's assets were invested primarily in fixed-income and equity securities, with approximately 18% and 14% of trust assets, net of liabilities, respectively, invested in alternative investments.

The Plan is administered by KFHP. Plan assets for Health Plan are not segregated and, accordingly, are not disclosed below. However, KFHP separately accounts for Health Plan liability and expense, and KFHP allocates pension expense and related prepaid or accrued benefit costs to Health Plan based on participant demographics and plan provisions.

At December 31, the funded status of the Plan was as follows (in millions):

	2014	2013
Change in projected benefit obligation (PBO):		
Benefit obligation at beginning of year	$ 12,964	$ 13,581
Change in accounting standard	—	291
Service cost	879	1,046
Interest cost	646	599
Special termination benefits	—	20
Plan amendments	1	—
Net actuarial loss (gain)	2,567	(2,075)
Benefits paid	(696)	(498)
Benefit obligation at end of year	$ 16,361	$ 12,964
Accumulated benefit obligation (ABO) at end of year	$ 12,453	$ 9,664
Change in KFHP's, Hospitals', and their subsidiaries' share of trust assets:		
Fair value of plan assets at beginning of year	$ 8,503	$ 7,329
Actual return on plan assets	627	816
Contributions	940	856
Benefits paid	(696)	(498)
Fair value of plan assets at end of year	9,374	8,503
Funded status	$ (6,987)	$ (4,461)

The measurement date used to determine pension valuations was December 31.

At December 31, the allocated funded status of the Plan and the amounts recognized in Health Plan's statement of financial position were as follows (in thousands):

	2014	2013
Funded status allocated to Health Plan	$ (333,493)	$ (222,898)
Liabilities recognized consist of:		
Accrued benefit cost	$ (65,887)	$ (54,494)
Liability for pension benefits	(215,535)	(88,763)
	$ (281,422)	$ (143,257)
Amounts recognized in unassigned surplus that have not been recognized as components of net periodic pension cost:		
Net actuarial loss	$ 265,371	$ 160,622
Prior service cost	2,235	7,782
	267,606	168,404
Unrecognized transition liability	(52,071)	(79,641)
Net amounts recognized in unassigned surplus	$ 215,535	$ 88,763

For the years ended December 31, pension expense amounts recognized in surplus allocated to Health Plan were as follows (in thousands):

	2014	2013
Service cost	$ 43,085	$ 47,952
Interest cost	30,531	29,833
Expected return on plan assets	(30,172)	(28,389)
Special termination benefits	—	—
Amortization of net actuarial loss	6,183	17,739
Amortization of prior service cost	5,547	5,548
Amortization of incremental asset	—	(1,766)
Net pension expense	55,174	70,917
Other changes in plan assets and benefit obligations recognized in capital and surplus:		
Change in additional minimum pension liability	—	(102,899)
Transition liability recognized	27,570	196,059
Net actuarial loss (gain)	110,932	(85,775)
Amortization of net actuarial loss	(6,183)	(17,739)
Prior service cost	—	—
Amortization of prior service cost	(5,547)	(5,548)
Amortization of incremental asset	—	1,766
Total recognized in surplus	126,772	(14,136)
Total recognized in net periodic benefit cost and surplus	$ 181,946	$ 56,781

During 2015, $15.9 million and $5.4 million of net actuarial loss and prior service cost, respectively, will be amortized from unassigned funds into net pension expense.

At December 31, 2014, the unrecognized transition liability allocated to Health Plan was as follows (in thousands):

Amount recognized for the year is the greater of:		
10% of initial surplus impact	$	27,570
Net amortization components of net periodic benefit cost	$	11,730
Amount to establish liability equal to the unfunded ABO	$	N/A
Unrecognized transition liability at December 31, 2013	$	(79,641)
Transition liability recognized		27,570
Additional transition liability recognized due to net actuarial gain and plan amendments		—
Total transition liability recognized during 2014		27,570
Unrecognized transition liability at December 31, 2014	$	(52,071)

Of the $52.1 million unrecognized transition liability at December 31, 2014, Health Plan will recognize annually at least $27.6 million as a reduction to surplus and will fully recognize the transition liability no later than 2016. Recognition amounts could change due to actual experience that differs from actuarial assumptions, or if Health Plan chooses to accelerate the reflection of the unrecognized transition liability.

Actuarial assumptions used were as follows:

	2014	2013
Weighted average discount rate at January 1 for calculating pension expense	5.15%	4.35%
Weighted average discount rate for calculating December 31 PBO	4.25%	5.15%
Weighted average salary scale for calculating pension expense and December 31 PBO	4.20%	4.60%
Expected long-term rate of return on plan assets for calculating pension expense	7.25%	7.50%

During 2015, Health Plan expects to contribute approximately $49.7 million to the Plan.

The following benefit payments, which reflect expected future service, are expected to be paid (in thousands):

2015	$	24,100
2016		26,700
2017		28,900
2018		31,300
2019		33,500
2020 - 2024		190,500

Explanation of Investment Strategies and Policies

A total return investment approach is employed for the Plan whereby the Plan invests in a mix of equity, fixed-income, and alternative asset classes to maximize the long-term return of plan assets for a prudent level of risk. The intent of this strategy is to minimize plan expenses by outperforming plan liabilities over the long run. Risk tolerance is established through consideration of plan liabilities, plan funded status, and corporate financial condition. The investment portfolio will consist over time of a varying but diversified blend of equity, fixed-income, and alternative investments. Diversification includes such factors as geographic location, equity capitalization size and style, placement in the capital structure, and security type. Investment risk is measured and monitored on an ongoing basis through annual liability measurements, periodic asset/liability studies, and quarterly investment portfolio reviews. The Plan's investment policy has restrictions relating to credit quality, industry/sector concentration, duration, concentration of ownership, and use of derivatives.

Capital Market Assumption Methodology

To determine the long-term rate of return assumption for plan assets, management incorporates historical relationships among the various asset classes and subclasses to be accessed over the investment horizon. Management's intent is to maximize portfolio efficiency. This will be accomplished by seeking the highest returns prudently available among the available asset classes. Overall portfolio volatility is managed through diversification among asset classes. Current market factors such as inflation and interest rates are evaluated before long-term capital market assumptions are determined. From time to time, management reviews its long-term investment strategy and reconciles that strategy with the long-term liabilities of the Plan. This asset-liability study produces a range of expected returns over medium and long-term time periods. Those intermediate and long-term investment projections form the basis for the expected long-term rate of return on assets.

At December 31, 2014, the estimated fair value of total pension trust assets - net by level was as follows (in millions):

	Quoted prices in active markets for identical assets level 1	Significant other observable inputs level 2	Significant unobservable inputs level 3	Total
Assets:				
Cash and cash equivalents	$ 82	$ 430	$ —	$ 512
Broker receivables	—	212	—	212
Securities lending collateral	—	1,593	—	1,593
U.S. equity securities	4,166	291	—	4,457
Foreign equity securities	4,092	1,762	—	5,854
Global equity funds	—	438	—	438
Debt securities issued by the U.S. government	—	718	—	718
Debt securities issued by U.S. government corporations and agencies	—	93	—	93
Debt securities issued by U.S. states and political subdivisions of states	—	213	—	213
Foreign government debt securities	—	537	—	537
U.S. corporate debt securities	—	3,955	—	3,955
Non-U.S. corporate debt securities	—	1,113	—	1,113
U.S. agency mortgage-backed securities	—	173	—	173
Non-U.S. agency mortgage-backed securities	—	53	—	53
Other	1	621	—	622
Alternative investments:				
Absolute return	—	897	1,118	2,015
Private equity	—	—	1,603	1,603
Risk parity	—	—	382	382
Total assets	8,341	13,099	3,103	24,543
Liabilities:				
Broker payables	—	293	—	293
Securities lending payable	—	1,593	—	1,593
Other liabilities	15	160	—	175
Total liabilities	15	2,046	—	2,061
Fair value of pension trust assets - net	$ 8,326	$ 11,053	$ 3,103	$ 22,482

At December 31, 2014, KFHP's, Hospitals', and their subsidiaries' share of pension trust assets was 41.7%, or $9.4 billion. The remaining share of pension trust assets is for independent medical groups and a related party associated with these independent medical groups.

At December 31, 2013, the estimated fair value of total pension trust assets - net by level was as follows (in millions):

	Quoted prices in active markets for identical assets level 1	Significant other observable inputs level 2	Significant unobservable inputs level 3	Total
Assets:				
Cash and cash equivalents	$ 71	$ 998	$ —	$ 1,069
Broker receivables	—	310	—	310
Securities lending collateral	—	1,434	—	1,434
U.S. equity securities	3,669	67	—	3,736
Foreign equity securities	4,161	1,552	—	5,713
Global equity funds	—	320	—	320
Debt securities issued by the U.S. government	—	681	—	681
Debt securities issued by U.S. government corporations and agencies	—	58	—	58
Debt securities issued by U.S. states and political subdivisions of states	—	169	—	169
Foreign government debt securities	—	402	—	402
U.S. corporate debt securities	—	3,535	—	3,535
Non-U.S. corporate debt securities	—	1,012	—	1,012
U.S. agency mortgage-backed securities	—	300	—	300
Non-U.S. agency mortgage- backed securities	—	90	—	90
Other	—	594	3	597
Alternative investments:				
Absolute return	—	851	774	1,625
Private equity	—	—	985	985
Risk parity	—	—	255	255
Total assets	7,901	12,373	2,017	22,291
Liabilities:				
Broker payables	—	405	—	405
Securities lending payable	—	1,434	—	1,434
Other liabilities	27	125	—	152
Total liabilities	27	1,964	—	1,991
Fair value of pension trust assets - net	$ 7,874	$ 10,409	$ 2,017	$ 20,300

At December 31, 2013, KFHP's, Hospitals', and their subsidiaries' share of pension trust assets was 41.9%, or $8.5 billion. The remaining share of pension trust assets is for independent medical groups and a related party associated with these independent medical groups.

For the year ended December 31, 2014, the reconciliation of assets with fair value measurements using significant unobservable inputs (level 3) was as follows (in millions):

	Debt securities	Alternative investments	Total
Beginning balance	$ 3	$ 2,014	$ 2,017
Transfers into level 3	—	—	—
Changes related to actual return on plan assets	—	218	218
Purchases, sales, and settlements - net	(3)	871	868
Ending balance	$ —	$ 3,103	$ 3,103
Total year-to-date net gains related to assets held at December 31, 2014	$ —	$ 218	$ 218

For the year ended December 31, 2013, the reconciliation of assets with fair value measurements using significant unobservable inputs (level 3) was as follows (in millions):

	Equity securities	Debt securities	Alternative investments	Total
Beginning balance	$ 2	$ 2	$ 1,340	$ 1,344
Transfers into Level 3	—	—	—	—
Changes related to actual return on plan assets	(1)	—	138	137
Purchases, sales, and settlements - net	(1)	1	536	536
Ending balance	$ —	$ 3	$ 2,014	$ 2,017
Total year-to-date net gains related to assets held at December 31, 2013	$ —	$ —	$ 138	$ 138

During the years ended December 31, 2014 and 2013, there were no significant transfers of assets with inputs with quoted prices in active markets for identical assets (level 1) and assets with inputs with significant other observable inputs (level 2).

The target asset allocation and expected long-term rate of return on assets (ELTRA) for calculating pension expense were as follows:

	2014 and 2013 target range	2014 ELTRA	2013 ELTRA
Cash and cash equivalents	0%-3%	3.00%	3.00%
Equity securities	43%-55%	8.65%	8.90%
Debt securities	28%-45%	5.50%	4.55%
Alternative investments	10%-25%	7.60%	8.20%
Total	100%	7.25%	7.50%

Alternative investments, which include absolute return, risk parity, and private equity, held in the pension trust are reported at net asset value as a practical expedient for fair value. Absolute return investments use advanced investment strategies, including derivatives, to generate positive long-term risk adjusted returns. Private equity investments consist of funds that make direct investments in private companies. Risk parity funds use risk as the primary factor to allocate investments among asset classes. At December 31, 2014, the trust had original commitments related to alternative investments of $3.8 billion, of which $1.5 billion was invested, leaving $2.3 billion of remaining commitments. At December 31, 2013, the trust had original commitments related to alternative investments of $2.6 billion, of which $911 million was invested, leaving $1.7 billion of remaining commitments.

Absolute return, risk parity, and private equity investments include redemption restrictions. Absolute return and risk parity investments require 10 to 90 day written notice of intent to withdraw and are often subject to the approval and capital requirements of the fund manager. Absolute return investments of $336 million are subject to lock-up periods of up to 4 years. Private equity agreements do not include provisions for redemption. Distributions will be received as the underlying investments of the funds are liquidated, which is expected over the next 11 years.

Health Plan Allocations

Health Plan's 2014 contributions made, benefits paid, PBO, ABO, and fair value of allocated plan assets were $43.8 million, $33.2 million, $780.9 million, $594.4 million, and $447.4 million, respectively. Health Plan's 2013 contributions made, benefits paid, PBO, ABO, and fair value of allocated plan assets were $38.4 million, $24.9 million, $647.7 million, $482.9 million, and $424.8 million, respectively.

(b) Defined Contribution Plans

KFHP administers defined contribution plans for eligible employees of Health Plan. Employer contributions and costs are typically based on a percentage of covered employees' eligible compensation. During 2014 and 2013, there were no required employee contributions. For the years ended December 31, 2014 and 2013, plan expense allocated to Health Plan, primarily employer contributions, was $9.3 million and $8.4 million, respectively.

(c) Multi-Employer Plan

Health Plan participates in a multi-employer defined benefit pension plan under the terms of a collective bargaining agreement that covers some union-represented employees. Some risks of participating in this multi-employer plan that differ from single-employer plans include:

- Assets contributed to the multi-employer plan by one employer may be used to provide benefits to employees of other participating employers.
- If a participating employer stops contributing to the plan, the unfunded obligations of the plan may be borne by the remaining participating employers.
- Employers that choose to stop participating in a multi-employer plan may be required to pay the plan an amount based on the underfunded status of the plan, referred to as a withdrawal liability.

Health Plan's participation in this plan for the annual period ended December 31, 2014 is outlined in the table below. The "EIN/PN" column provides the Employee Identification Number (EIN) and the three-digit plan number (PN). The most recent Pension Protection Act (PPA) zone status available in 2014 and 2013 is for the plan's year-end in 2013 and 2012, respectively. The zone status is based on information that Health Plan obtained from publicly available information provided by the United States Department of Labor. Among other factors, plans in the red zone are generally less than 65% funded, plans in the yellow zone are between 65% and 80% funded, and plans in the green zone are at least 80% funded. The "FIP/RP Status Pending/Implemented" column indicates plans for which a financial improvement plan (FIP) or a rehabilitation plan (RP) is either pending or has been implemented. The "Health Plan's Contributions to Plan Exceeded More Than 5% of Total Contributions" columns represent those plans where Health Plan was listed in the plans' Form 5500 as providing more than 5% of the total contributions for the plan years listed. The last column lists the expiration dates of the collective bargaining agreement to which the plan is subject. There have been no significant changes that affect the comparability of 2014 and 2013 employer expense. Minimum contributions, based on contract rates, are required to be made monthly.

					(in thousands)					
		Pension Protection Act Zone Status		FIP/RP Status Pending /	Health Plan's Contributions December 31,			Health Plan's Contributions to Plan Exceeded More Than 5% of Total Contributions [1]		Expiration Date of Collective Bargaining
Pension Fund	EIN-PN	2014	2013	Implemented	2014	2013	Surcharge Imposed	2013	2012	Agreement
Central Pension Fund of the IUOE and Participating Employers	366052390-001	Green	Green	N/A	$ 227	$ 352	No	No	No	3/7/2016

(1) At the date the financial statements were issued, Form 5500 was not available for the plan year ending during 2014.

(10) Postretirement Benefits Other than Pensions

Certain employees may become eligible for postretirement health care and life insurance benefits while working for Health Plan. Benefits available to retirees, through both affiliated and unaffiliated provider networks, vary by employee group. Postretirement health care benefits available to retirees include subsidized Medicare premiums, medical and prescription drug benefits, dental benefits, and vision benefits.

In September 2013, the postretirement health care and life insurance benefit plans of KFHP, Hospitals, and their subsidiaries were modified for certain nonunion represented employees. Employees of Health Plan were not affected by the plan amendments. On September 30, 2013, Health Plan's postretirement health care and life insurance liability was remeasured as a result of this modification, and actuarial assumptions were updated, leading to different assumptions for discount rate and health care trend rates for the nine months ended September 30, 2013 versus the three months ended December 31, 2013.

At December 31, Health Plan's accrued liability for postretirement benefits was as follows (in thousands):

	2014	2013
Change in benefit obligation:		
Benefit obligation at beginning of year	$ 53,710	$ 27,896
Change in accounting standard	—	25,347
Service cost	2,361	2,563
Interest cost	2,537	2,394
Plan amendments	—	50
Plan clarifications	(1,213)	—
Benefits paid or provided	(1,442)	(1,468)
Net actuarial loss (gain)	16,399	(3,072)
Benefit obligation at end of year	72,352	53,710
Change in plan assets:		
Fair value of plan assets at beginning of year	—	—
Actual return on plan assets	—	—
Contributions	3,822	1,468
Benefits paid or provided	(1,442)	(1,468)
Fair value of plan assets at end of year	$ 2,380	$ —
Funded status	$ (69,972)	$ (53,710)

	2014	2013
Liabilities recognized consist of:		
Accrued benefit cost	$ (30,430)	$ (27,052)
Postretirement benefit liability	(21,411)	(4,116)
Total postretirement benefit liabilities recognized	$ (51,841)	$ (31,168)
Amounts recognized in unassigned surplus that have not been recognized as components of benefits expense:		
Net actuarial loss	$ 18,036	$ 2,850
Prior service cost	21,506	23,808
Amounts recognized in unassigned surplus	39,542	26,658
Unrecognized transition liability	(18,131)	(22,542)
Net amounts recognized in unassigned surplus	$ 21,411	$ 4,116

The measurement date used to determine postretirement benefits valuations was December 31.

For the years ended December 31, postretirement benefits expense and amount recognized in surplus were as follows (in thousands):

	2014	2013
Service cost	$ 2,361	$ 2,563
Interest cost	2,537	2,394
Expected return on plan assets	—	—
Amortization of prior service cost	2,302	2,299
Amortization of net actuarial loss	—	—
Postretirement benefits expense	7,200	7,256
Other changes in plan assets and benefit obligations recognized in unassigned surplus:		
Transition liability recognized	4,411	9,437
Prior service cost	—	50
Amortization of prior service cost	(2,302)	(2,299)
Plan clarifications	(1,213)	—
Net actuarial loss (gain)	16,399	(3,072)
Amortization of net actuarial loss	—	—
Total recognized in surplus	17,295	4,116
Total recognized in net periodic benefit cost and surplus	$ 24,495	$ 11,372

During 2015, $2.3 million and $692 thousand of prior service cost and net actuarial loss, respectively, will be amortized from unassigned surplus into postretirement benefits expense.

During 2014, the employer contributions and benefits paid or provided were $3.8 million and $1.4 million, respectively. In December 2014, $2.4 million was deposited into a retirement benefits trust account to fund the postretirement benefits of certain employees. During 2013, the employer contributions and benefits paid or provided were $1.5 million. During 2014 and 2013, there were no participant contributions from active employees.

At December 31, 2014, the unrecognized transition liability was as follows (in thousands):

Amount recognized for 2014 is the greater of:		
10% of initial surplus impact	$	3,198
Net amortization components of net periodic benefit cost	$	2,302
Unrecognized transition liability at December 31, 2013	$	(22,542)
Transition liability recognized		3,198
Additional transition liability recognized due to net actuarial gains		1,213
Total transition liability recognized during 2014		4,411
Unrecognized transition liability at December 31, 2014	$	(18,131)

Of the $18.1 million unrecognized transition liability at December 31, 2014, Health Plan will recognize annually at least $3.2 million as a reduction to surplus and will fully recognize the transition liability no later than 2020. Recognition amounts could change due to actual experience that differs from actuarial assumptions or if Health Plan chooses to accelerate the reflection of the unrecognized transition liability.

Actuarial assumptions used were as follows:

	2014	2013
Weighted average discount rate for calculating postretirement benefits expense from January 1 to September 30	5.25%	4.60%
Weighted average discount rate for calculating postretirement benefits expense from September 30 to December 31	5.25%	5.30%
Weighted average discount rate for calculating December 31 accumulated postretirement benefit obligation	4.35%	5.25%

The following were the assumed health care cost trend rates used to determine postretirement benefits expense for the nine months ended September 30, 2013:

	Basic medical Pre-65/Post-65	Prescription drug Pre-65/Post-65	Medicare Part D	Dental	Medicare Part A&B	Supplemental medical
Initial trend rate - 2013	7.50% / 6.75%	6.50% / 6.50%	6.70%	4.50%	6.25%	7.50%
Ultimate trend rate	4.50% / 4.50%	4.50% / 4.50%	4.50%	4.50%	4.50%	4.50%
First year at ultimate trend rate	2026 / 2022	2025 / 2025	2025	2013	2020	2026

The following were the assumed health care cost trend rates used to determine the December 31, 2013 benefit obligation and postretirement benefits expense for the three months ended December 31, 2013 and twelve months ended December 31, 2014:

	Basic medical Pre-65/Post-65	Prescription drug Pre-65/Post-65	Medicare Part D	Dental	Medicare Part A&B	Supplemental medical Pre-65/Post-65
Initial trend rate - 2013	7.00% / 6.00%	6.00% / 6.00%	-10.00%	4.50%	5.50%	7.00% / 6.00%
Initial trend rate - 2014	7.00% / 6.00%	6.00% / 6.00%	6.00%	4.50%	5.50%	7.00% / 6.00%
Ultimate trend rate	4.50% / 4.50%	4.50% / 4.50%	4.50%	4.50%	4.50%	4.50% / 4.50%
First year at ultimate trend rate	2026 / 2022	2025 / 2025	2025	2013	2020	2026 / 2022

The following were the assumed health care cost trend rates used to determine the December 31, 2014 benefit obligation:

	Basic medical Pre-65/Post-65	Prescription drug Pre-65/Post-65	Medicare Part D	Dental	Medicare Part A&B	Supplemental medical Pre-65/Post-65
Initial trend rate - 2014	5.50% / 5.25%	9.00% / 9.00%	4.00%	4.50%	5.25%	5.50% / 5.25%
Ultimate trend rate	4.50% / 4.50%	4.50% / 4.50%	4.50%	4.50%	4.50%	4.50% / 4.50%
First year at ultimate trend rate	2026 / 2022	2025 / 2025	2026	2014	2022	2026 / 2022

A 1% increase in the health care medical trend rate would increase the benefit obligation by $2.7 million and the service cost plus interest by $118 thousand. A decrease of 1% in the health care medical trend rate would decrease the benefit obligation by $2.3 million and the service cost plus interest by $103 thousand.

The following benefits payments, which reflect expected future service, are expected to be paid or provided (in thousands):

2015	$ 1,961
2016	2,183
2017	2,365
2018	2,706
2019	3,028
2020 - 2024	19,996

In January 2015, KFHP and Hospitals modified postretirement health care benefits for certain union represented employees. Employees of Health Plan were not affected by this plan amendment. However, the postretirement benefits plan which included union represented employees was remeasured using updated actuarial assumptions. The impact of the remeasurement will result in an increase in 2015 liabilities of $4.2 million.

(11) Information about Financial Instruments with Concentration of Credit Risk

Financial instruments that potentially subject Health Plan to concentrations of credit risk consist primarily of investment securities and accounts receivable. All investments in securities are managed within guidelines established by Health Plan's management, which, as a matter of policy, limit the amounts that may be

invested in each type of security, with any one issuer, and in various credit quality classifications. Concentration of credit risk with respect to accounts receivable is limited due to the large number of payers comprising Health Plan's customer base. Accordingly, at December 31, 2014 and 2013, Health Plan does not believe any significant concentration of credit risk existed.

(12) Commitments and Contingencies

(a) Operating Leases and Purchase Commitment

Health Plan leases primarily office space, medical facilities, and equipment under various leases that expire through 2036. Certain leases contain rent escalation clauses and renewal options for additional periods.

At December 31, 2014, minimum commitments under noncancelable leases extending beyond one year were as follows (in thousands):

2015	$	24,385
2016		24,220
2017		20,625
2018		17,428
2019		15,144
Thereafter		61,547
Total	$	163,349

For the years ended December 31, total lease expense for all leases was as follows (in thousands):

	2014	2013
Minimum rentals	$ 29,153	$ 27,366
Imputed rent for owned and occupied medical and administrative building	49,849	42,703
Less sublease rentals	—	—
Total	$ 79,002	$ 70,069

Health Plan has entered into long-term agreements that require certain minimum purchases of goods and services. These commitments are at levels that are consistent with normal business requirements.

At December 31, 2014, minimum purchase commitments extending beyond one year were as follows (in thousands):

2015	$	119
2016		119
2017		6
2018		2
2019		—
Thereafter		—
	$	246

During 2014 and 2013, Health Plan's total purchases under contracts with minimum purchase commitments were $11 thousand and $69 thousand, respectively.

(b) Regulatory

Health Plan is subject to numerous and complex laws and regulations of federal, state, and local governments, and accreditation requirements. Compliance with such laws, regulations, and accreditation requirements can be subject to retrospective review and interpretation, as well as regulatory actions. These laws and regulations include, but are not necessarily limited to, requirements of tax exemption, government reimbursement, government program participation, privacy and security, false claims, anti-kickback, accreditation, healthcare reform, controlled substances, facilities, and professional licensure. In recent years, government activity has increased with respect to compliance and enforcement actions.

In the ordinary course of our business operations, Health Plan is subject to periodic reviews, investigations, and audits by various federal, state, and local regulatory agencies and accreditation agencies, including, without limitation, CMS, USOPM, Occupational Safety and Health Administration, Drug Enforcement Administration, State Boards of Pharmacy, Food and Drug Administration, IRS, National Committee for Quality Assurance, and state departments of insurance.

Health Plan's compliance with the wide variety of rules and regulations and accreditation requirements applicable to its business may result in certain remediation activities and regulatory fines and penalties, which could be substantial. Where appropriate, reserves have been established for such sanctions. While management believes these reserves are adequate, the outcome of legal and regulatory matters is inherently uncertain, and it is possible that one or more of the legal or regulatory matters currently pending or threatened could have a material adverse effect on the financial position or results of operations.

(c) Litigation

Health Plan is involved in lawsuits and various governmental investigations, audits, reviews, and administrative proceedings arising, for the most part, in the ordinary course of business operations. Lawsuits have been brought under a wide range of laws and include, but are not limited to, business disputes, employment and retaliation claims, claims alleging professional liability, improper disclosure

of personal information, labor disputes, administrative regulations, the False Claims Act, information privacy and HIPAA laws, mental health parity laws, and consumer protection laws. In addition, Health Plan indemnifies the Medical Group against various claims, including professional liability claims.

Health Plan records reserves for legal proceedings and regulatory matters where available information indicates that at the date of the financial statements a loss is probable and the amount can be reasonably estimated. While such reserves reflect management's best estimate of the probable loss for such matters, Health Plan's recorded amount may differ materially from the actual amount of any such losses.

In the opinion of management, based upon current facts and circumstances, the resolution of these matters is not expected to have a material adverse effect on the financial position or results of operations of Health Plan. The outcome of litigation and other legal and regulatory matters is inherently uncertain, however, and it is possible that one or more of the legal or regulatory matters currently pending or threatened could have a material adverse effect.

(13) Minimum Capital and Surplus

Health Plan is required to periodically file financial statements with regulatory agencies in accordance with statutory accounting and reporting practices. Health Plan must comply with the regulatory capital and surplus requirements under the regulation of the MIA. Such requirements are generally based on 100% of RBC. At December 31, 2014 and 2013, the regulatory capital and surplus of Health Plan exceeded the authorized control level by approximately $93.5 million and $122.7 million, respectively.

In accordance with Maryland code, Health Plan must receive prior written approval from the MIA to pay a dividend or distribution during 2015 which, when combined with dividends or distributions paid within the preceding 12 months, exceeds the greater of either (a) 10% of Health Plan's statutory capital and surplus at December 31, 2014, or (b) Health Plan's net gain from operations on a statutory basis for the year ended December 31, 2014. Accordingly, during 2015, prior approval from the MIA is required for any dividend or distribution payment which exceeds $14.7 million.

Subordinated notes (the Notes) issued by Health Plan to Hospitals were as follows (in thousands):

Issue date	Due date	Interest Rate	Amount as of December 31 2014	2013
December 28, 2011	December 28, 2018	7.50%	$ 50,000	$ 50,000
March 28, 2012	March 28, 2019	7.50%	45,000	45,000
December 28, 2012	December 28, 2019	7.50%	38,000	38,000
March 28, 2014	March 28, 2021	7.50%	31,000	—
December 30, 2014	December 29, 2021	5.00%	100,000	—
	Total		$ 264,000	$ 133,000

Payment of principal or interest is subject to approval by the Commissioner of the MIA. Payment of the principal or interest of these Notes is subordinated to the prior payment of all general liabilities of Health Plan and the claims of its policyholders, beneficiaries and claimants, and all classes of creditors. The Notes

have been recorded as a component of statutory capital and surplus; additionally, no accrued interest has been recorded as approval for payment has not been obtained from the MIA. At December 31, 2014 and 2013, unapproved interest payable totaled $15.0 million and $10.4 million, respectively. The Notes, which have been issued to maintain risk-based capital requirements, have been recorded as an increase to capital for statutory purposes. Unapproved interest payable is not accrued for statutory purposes. The $100.0 million received in conjunction with the subordinated note issued on December 30, 2014 was held as cash in a single financial institution at December 31, 2014.

Beginning January 1, 2013, Hospitals waived, on a prospective basis, certain amounts of interest on the Notes issued as of December 19, 2012, and any notes issued after December 19, 2012, to the extent interest due per the terms of the Notes exceeds the cost of debt to Hospitals, which is determined on a monthly basis. The waiver extends for four consecutive rolling quarters, subject to termination and reversion by Hospitals. Hospitals will provide notice 30 days prior to the start of any quarter, informing Health Plan of the termination of the waiver and that the interest rate will revert to the rate stated in the Notes, which termination and reversion shall become effective at the end of four consecutive quarters from the date of the notice. The average interest rate charged by Hospitals to Health Plan during 2014 and 2013 was 2.90% and 3.01%, respectively.

(14) Liquidity

At December 31, 2014, due in part to the subordinated notes issued, Health Plan has positive statutory capital and surplus totaling $147.2 million. The statutory capital and surplus represents 274% of risk-based capital. However, at December 31, 2014, Health Plan's GAAP net deficit is $141.4 million, an increase of $120.5 million from December 31, 2013. The increase in GAAP net deficit is primarily due to the net loss of $4.3 million in 2014 and a $115.6 million increase in net deficit pertaining to the pension and postretirement liabilities. Health Plan has sufficient liquidity to fund both operations and capital expenditures in order to continue as a going concern via its cash and investments. Additionally, Health Plan has a guaranty agreement with the parent, KFHP and affiliates, in which the parent and Hospitals, without exception, guarantee all obligations of Health Plan.

(15) Annual Statement Reconciliation

The following is a reconciliation of differences between accompanying statutory basis financial statements and the annual statement filed with the Maryland Insurance Administration for the 2013 reporting year (in thousands):

KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.

Notes to Statutory Financial Statements

December 31, 2014 and 2013

	As listed in the audited statutory financial statements	As listed in the filed statutory annual statement
2013:		
Statutory statement of revenues and expenses:		
Net premium revenue [1, 2, 4]	$ 2,101,409	$ 2,374,702
Change in unearned premium reserves and reserve for rate credits [2]	—	1,380
Fee-for-service [3]	—	31,944
Medicare cost contract revenue [1]	277,734	—
Other revenue [3, 5]	34,981	1,092
Hospital and medical benefits [4]	808,258	807,573
Other professional services [6]	648,882	628,215
Claims adjustment expenses [6]	139,895	160,562
General administrative expenses [4, 5]	68,849	64,528

(1) Medicare cost contract revenue and reserve classification changes made for audited statutory financial statement disclosure purposes only.

(2) Reclassification of $1.4 million of revenue from change in unearned premium reserves and reserve for rate credits to net premium revenue.

(3) Reclassification of $31.9 million of revenue from fee-for-service revenue to other revenue.

(4) Reclassification of $3.1 million and $(685) thousand of bad debt expense from net premium revenue and hospital and medical benefits, respectively, to general administrative expenses.

(5) Reclassification of $1.9 million of reimbursements by uninsured plans from general administrative expenses to other revenue.

(6) Reclassification of $20.7 million of expenses from claims adjustment expenses to other professional services.

(16) Risk-Sharing Provisions of the Affordable Care Act

Risk-sharing provisions relating to the PPACA were as follows (in thousands):

		December 31, 2014
a.	ACA Permanent Risk Adjustment Program	
i.	Premium adjustments receivable due to ACA Risk Adjustment	$ —
ii.	Risk adjustment user fees payable for ACA Risk Adjustment	32
iii.	Premium adjustments payable due to ACA Risk Adjustment	—
iv.	Reported as revenue in premium for accident and health contracts (written/collected) due to ACA Risk Adjustment	—
v.	Reported in expenses as ACA Risk Adjustment user fees (incurred/paid)	32
b.	ACA Transitional Reinsurance Program	
i.	Amounts recoverable for claims paid due to ACA Reinsurance	$ 3,165
ii.	Amounts recoverable for claims unpaid due to ACA Reinsurance (contra-liability)	2,296
iii.	Amounts receivable relating to uninsured plans for contributions for ACA Reinsurance	—
iv.	Liabilities for contributions payable due to ACA Reinsurance - not reported as ceded premium	27,010
v.	Ceded reinsurance premiums payable due to ACA Reinsurance	1,162
vi.	Liability for amounts held under uninsured plans contributions for ACA Reinsurance	—
vii.	Ceded reinsurance premiums due to ACA Reinsurance	1,162
viii.	Reinsurance recoveries (income statement) due to ACA Reinsurance payments or expected payments	5,461
ix.	ACA Reinsurance Contributions - not reported as ceded premium	27,010
c.	ACA Temporary Risk Corridors Program	
i.	Accrued retrospective premium due from ACA Risk Corridors	$ —
ii.	Reserve for rate credits or policy experience rating refunds due to ACA Risk Corridors	—
iii.	Effect of ACA Risk Corridors on net premium income (paid/received)	—
iv.	Effect of ACA Risk Corridors on change in reserves for rate credits	—

There were no prior year PPACA risk-sharing provisions at December 31, 2014. Accordingly, no roll forward table is included.

(17) Subsequent Events

On March 31, 2015, Health Plan issued a subordinated note to Hospitals in the amount of $50.0 million with interest payable annually at 5.00%. The subordinated note is payable seven years from issuance and is due on March 31, 2022. Payment of principal and interest is subject to approval by the Insurance Commissioner of the State of Maryland.

Schedule I

KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.

Statutory Supplemental Schedule of Investment Information - Summary Investment Schedule

December 31, 2014

Investment categories	Gross investment holdings* Amount	Gross investment holdings* Percentage of gross investment holdings	Admitted invested assets as reported in the annual statement Amount	Admitted invested assets as reported in the annual statement Percentage of admitted invested assets
Bonds:				
U.S. Treasury securities	$ 86,198,206	9.18%	$ 86,198,206	9.18%
U.S. government agency obligations (excluding mortgage-backed securities):				
Issued by U.S. government agencies	—	—	—	—
Issued by U.S. government-sponsored agencies	11,814,106	1.26%	11,814,106	1.26%
Foreign government (including Canada, excluding mortgage-backed securities)	703,331	0.07%	703,331	0.07%
Securities issued by states, territories, and possessions and their political subdivisions in the U.S.:				
States, territories, and possessions – general obligations	339,526	0.04%	339,526	0.04%
Political subdivisions of states, territories, and possessions - general obligations	—	—	—	—
Revenue and assessment obligations	1,158,364	0.12%	1,158,364	0.12%
Industrial development and similar obligations	—	—	—	—
Mortgage-backed securities (includes residential and commercial MBS):				
Pass-through securities:				
Guaranteed or issued by GNMA	—	—	—	—
Guaranteed or issued by FNMA and FHLMC	924,458	0.10%	924,458	0.10%
All other	—	—	—	—
CMOs and REMICs:				
Issued or guaranteed by GNMA, FNMA, FHLMC, or VA	11,195,390	1.19%	11,195,390	1.19%
Issued by non-U.S. government issuers and collateralized by MBS; issued or guaranteed by GNMA, FNMA, FHLMC, or VA	—	—	—	—
All other	11,849,347	1.26%	11,849,347	1.26%
Other debt and other fixed income securities (excluding short term):				
Unaffiliated domestic securities (includes credit tenant loans and hybrid securities)	86,406,275	9.20%	86,406,275	9.20%
Unaffiliated foreign securities (including Canada)	31,690,279	3.38%	31,690,279	3.38%
Affiliated securities	—	—	—	—
Equity interests:				
Investments in mutual funds	—	—	—	—
Preferred stocks:				
Affiliated	—	—	—	—
Unaffiliated	—	—	—	—
Publicly traded equity securities (excluding preferred stocks):				
Affiliated	—	—	—	—
Unaffiliated	—	—	—	—

Schedule I

KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.

Statutory Supplemental Schedule of Investment Information - Summary Investment Schedule

December 31, 2014

Investment categories	Gross investment holdings*		Admitted invested assets as reported in the annual statement	
	Amount	Percentage of gross investment holdings	Amount	Percentage of admitted invested assets
Other equity securities:				
Affiliated	$ —	—	$ —	—
Unaffiliated	—	—	—	—
Other equity interests including tangible personal property under lease:				
Affiliated	—	—	—	—
Unaffiliated	—	—	—	—
Mortgage loans:				
Construction and land development	—	—	—	—
Agricultural	—	—	—	—
Single-family residential properties	—	—	—	—
Multifamily residential properties	—	—	—	—
Commercial loans	—	—	—	—
Real estate investments:				
Property occupied by company	588,590,538	62.69%	588,590,538	62.69%
Property held for production of income	3,899,265	0.42%	3,899,265	0.42%
Property held for sale	—	—	—	—
Collateral loans	—	—	—	—
Policy loans	—	—	—	—
Receivables for securities	2,162,146	0.23%	2,162,146	0.23%
Cash (overdraft) and short-term investments - net	101,946,192	10.86%	101,946,192	10.86%
Other invested assets	—	—	—	—
Total invested assets	$ 938,877,423	100.00%	$ 938,877,423	100.00%

* Gross investment holdings as valued in compliance with *NAIC Accounting Practices and Procedures Manual*.

See accompanying independent auditors' report.

KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.

Statutory Supplemental Schedule of Investment Information - Investment Risks Interrogatories

December 31, 2014

1. Health Plan's total admitted assets as reported on page two of its Annual Statement are $ 1,196,400,743
2. The following are the 10 largest exposures to a single issuer/borrower/investment by investment category, excluding: (i) U.S. government, U.S. government agency securities, and those U.S. government money market funds listed in the Appendix to the *SVO Practices and Procedures Manual* as exempt, (ii) property occupied by Health Plan and (iii) policy loans:

Investment category/issuer		Amount	Percentage of total admitted assets
Bonds:			
a. Bond	JP Morgan Chase & Co	$ 7,167,990	0.60%
b. Bond	Bank of America	5,872,737	0.49%
c. Bond	Citigroup Inc	4,972,846	0.42%
d. Bond	Fannie Mae	4,422,916	0.37%
e. Bond	Santander Drive Auto Receivables Trust	3,989,848	0.33%
f. Bond	Nissan	3,780,214	0.32%
g. Money Market Fund	SSGA	2,936,834	0.25%
h. Bond	AmeriCredit Automobile Receivables Trust	2,902,664	0.24%
i. Bond	General Electric	2,878,379	0.24%
j. Bond	Freddie Mac	2,840,002	0.24%

3. Health Plan's total admitted assets held in bonds and preferred stocks, by NAIC rating, are:

Bonds			Preferred stocks		
NAIC rating	Amount	Percentage of total admitted assets	NAIC rating	Amount	Percentage of total admitted assets
NAIC - 1	$ 213,874,083	17.88%	P/PSF-1	$ —	—
NAIC - 2	30,847,303	2.58%	P/PSF-2	—	—
NAIC - 3	848,232	0.07%	P/PSF-3	—	—
NAIC - 4	—	—	P/PSF-4	—	—
NAIC - 5	—	—	P/PSF-5	—	—
NAIC - 6	—	—	P/PSF-6	—	—
	$ 245,569,618			$ —	

4. Assets held in foreign investments are less than 2.5% of Health Plan's total admitted assets. Yes [X] No [ ]

	Amount	Percentage of total admitted assets
Total admitted assets held in foreign investment at December 31, 2014.	$ 28,440,652	2.38%
Foreign-currency-denominated investments.	—	—
Insurance liabilities denominated in that same foreign currency.	—	—

5. Aggregate foreign investment exposure categorized by NAIC sovereign rating:

	Amount	Percentage of total admitted assets
Countries rated NAIC-1	$ —	—
Countries rated NAIC-2	—	—
Countries rated NAIC-3 or below	—	—

Schedule II

KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.

Statutory Supplemental Schedule of Investment Information - Investment Risks Interrogatories

December 31, 2014

6. Two largest foreign investment exposures to a single country, categorized by the country's NAIC sovereign rating:

		Amount	Percentage of total admitted assets
Countries rated NAIC-1:			
Country 1:	$	—	—
Country 2:		—	—
Countries rated NAIC-2:			
Country 1:	$	—	—
Country 2:		—	—
Countries rated NAIC-3 or below:			
Country 1:	$	—	—
Country 2:		—	—

		Amount	Percentage of total admitted assets
7. Aggregate unhedged foreign currency exposure:	$	—	—

8. Aggregate unhedged foreign currency exposure categorized by NAIC sovereign rating:

		Amount	Percentage of total admitted assets
Countries rated NAIC-1	$	—	—
Countries rated NAIC-2		—	—
Countries rated NAIC-3 or below		—	—

9. Two largest unhedged foreign currency exposures to a single country, categorized by the country's NAIC sovereign rating:

		Amount	Percentage of total admitted assets
Countries rated NAIC-1:			
Country 1:	$	—	—
Country 2:		—	—
Countries rated NAIC-2			
Country 1:	$	—	—
Country 2:		—	—
Countries rated NAIC-3 or below:			
Country 1:	$	—	—
Country 2:		—	—

10. Ten largest nonsovereign (i.e., nongovernmental) foreign issues:

Issuer	NAIC rating		Amount	Percentage of total admitted assets
a.		$	—	—
b.			—	—
c.			—	—
d.			—	—
e.			—	—
f.			—	—
g.			—	—
h.			—	—
i.			—	—
j.			—	—

11. Assets held in Canadian investments are less than 2.5% of Health Plan's total assets. Yes [X] No [ ]

KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.

Statutory Supplemental Schedule of Investment Information - Investment Risks Interrogatories

December 31, 2014

12. Assets held in investments with contractual sales restrictions are less than 2.5% of Health Plan's total admitted assets. Yes [X] No [ ]

13. Assets held in equity interests are less than 2.5% of Health Plan's total admitted assets. Yes [X] No [ ]

Ten largest assets held in equity interests:

	Issuer	Amount	Percentage of total admitted assets
a.		$ —	—
b.		—	—
c.		—	—
d.		—	—
e.		—	—
f.		—	—
g.		—	—
h.		—	—
i.		—	—
j.		—	—

14. Assets held in nonaffiliated, privately placed equities are less than 2.5% of Health Plan's total admitted assets. Yes [X] No [ ]

15. Assets held in general partnership interests are less than 2.5% of Health Plan's total admitted assets. Yes [X] No [ ]

16. Mortgage loans reported in schedule B are less than 2.5% of Health Plan's total admitted assets. Yes [X] No [ ]

17. Assets held in each of the five largest investments in one parcel or group of contiguous parcels or real estate reported in Schedule A are less than 2.5% of Health Plan's total admitted assets. Yes [X] No [ ]

Largest five investments in any one parcel or group of contiguous parcels of real estate:

	Description	Amount	Percentage of total admitted assets
a.		$ —	—
b.		—	—
c.		—	—
d.		—	—
e.		—	—

18. Are assets held in investments held in mezzanine real estate loans less than 2.5% of the Health Plan's total admitted assets. Yes [X] No [ ]

19. Amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements:

	At Year-end		At End of Each Quarter 1st Qtr	2nd Qtr	3nd Qtr
Securities lending agreements (do not include assets held as collateral for such transactions)	$ —	—	—	—	—
Repurchase agreements	—	—	—	—	—
Reverse repurchase agreements	—	—	—	—	—
Dollar repurchase agreements	—	—	—	—	—
Dollar reverse repurchase agreements	—	—	—	—	—

20. Amounts and percentages of the reporting entity's total admitted assets for warrants not attached to other financial instruments, options, caps, and floors:

	Owned		Written	
Hedging	$ —	—	—	—
Income generation	—	—	—	—
Other	—	—	—	—

KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.

Statutory Supplemental Schedule of Investment Information - Investment Risks Interrogatories

December 31, 2014

21. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for collars, swaps, and forwards:

	At Year-end		At End of Each Quarter 1st Qtr		2nd Qtr		3rd Qtr	
Hedging	$ —	—	$ —	$ —		$ —		—
Income generation	—	—	—	—		—		—
Replications	—	—	—	—		—		—
Other	—	—	—	—		—		—

22. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for futures contracts:

	At Year-end		At End of Each Quarter 1st Qtr		2nd Qtr		3rd Qtr	
Hedging	$ —	—	$ —	$ —		$ —		—
Income generation	—	—	—	—		—		—
Replications	—	—	—	—		—		—
Other	—	—	—	—		—		—

See accompanying independent auditors' report.

Exhibit 8

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

Signature

2/3/16

Date

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

Signature

2/1//2016
Date

Exhibit 9

TABLE C. CONSTRUCTION CHARACTERISTICS

INSTRUCTION: If project includes non-hospital space structures (e.g., parking garges, medical office buildings, or energy plants), complete an additional Table C for each structure.

	NEW CONSTRUCTION	RENOVATION
BASE BUILDING CHARACTERISTICS	**Check if applicable**	
Class of Construction (for renovations the class of the building being renovated)*		
Class A	☐	☑
Class B	☐	☐
Class C	☐	☐
Class D	☐	☐
Type of Construction/Renovation*		
Low	☐	☐
Average	☐	☐
Good	☐	☑
Excellent	☐	☐
Number of Stories		

*As defined by Marshall Valuation Service

PROJECT SPACE	**List Number of Feet, if applicable**	
Total Square Footage	**Total Square Feet**	
Basement		
First Floor		
Second Floor		491
Third Floor		
Fourth Floor		
Average Square Feet		
Perimeter in Linear Feet	**Linear Feet**	
Basement		
First Floor		
Second Floor		101
Third Floor		
Fourth Floor		
Total Linear Feet		
Average Linear Feet		
Wall Height (floor to eaves)	**Feet**	
Basement		
First Floor		
Second Floor		13
Third Floor		
Fourth Floor		
Average Wall Height		
OTHER COMPONENTS		
Elevators	**List Number**	
Passenger		
Freight		
Sprinklers	**Square Feet Covered**	
Wet System		
Dry System		
Other	**Describe Type**	
Type of HVAC System for proposed project		
Type of Exterior Walls for proposed project		

TABLE E. PROJECT BUDGET

INSTRUCTION: Estimates for Capital Costs (1.a-e), Financing Costs and Other Cash Requirements (2.a-g), and Working Capital Startup Costs (3) must reflect current costs as of the date of application and include all costs for construction and renovation. Explain the basis for construction cost estimates, renovation cost estimates, contingencies, interest during construction period, and inflation in an attachment to the application. See additional instruction in the column to the right of the table.

NOTE: Inflation should only be included in the inflation allowance line A.1.e. The value of donated land for the project should be included on Line A.1.a as a use of funds and on line B.8 as a source of funds

	Hospital Building	Other Structure	Total	Additional instruction for cost categories
A. USE OF FUNDS				
1. CAPITAL COSTS				
a. Land Purchase			$0	
b. New Construction				
(1) Building			$0	
(2) Fixed Equipment			$0	These costs should be consistent with the Marshall Valuation Service definition of Group 1 equipment: Permanent equipment, installed on or attached to the building, part of a general contract, and included in calculator costs.
(3) Site and Infrastructure			$0	
(4) Architect/Engineering Fees			$0	
(5) Permits (Building, Utilities, Etc.)			$0	
SUBTOTAL	$0	$0	$0	Ensure that SUBTOTAL includes all categories under 1 b
c. Renovations				
(1) Building		$366,006	$366,006	
(2) Fixed Equipment (not included in construction)			$0	
(3) Architect/Engineering Fees		$27,450	$27,450	
(4) Permits (Building, Utilities, Etc.)		$10,000	$10,000	
SUBTOTAL	$0	$403,456	$403,456	Ensure that SUBTOTAL includes all categories under 1 c.
d. Other Capital Costs				
(1) Movable Equipment		$822,070	$822,070	
(2) Contingency Allowance		$136,000	$136,000	
(3) Gross interest during construction period			$0	
(4) Other *(Owner's Misc. and Project Management)*		$113,091	$113,091	
SUBTOTAL		$1,071,161	$1,071,161	Calculate sum of all categories under 1 d.
TOTAL CURRENT CAPITAL COSTS	$0	$1,474,617	$1,474,617	Ensure that TOTAL CURRENT CAPITAL COSTS includes all SUBTOTALS above
e. Inflation Allowance		$16,238	$16,238	Inflation should only be included in this category
TOTAL CAPITAL COSTS	$0	$1,490,855	$1,490,855	Ensure that TOTAL CAPITAL COSTS includes TOTAL CURRENT CAPITAL COSTS and Inflation Allowance
2. Financing Cost and Other Cash Requirements				
a. Loan Placement Fees			$0	
b. Bond Discount			$0	
c. Legal Fees			$0	
d. Non-Legal Consultant Fees		$109,550	$109,550	
e. Liquidation of Existing Debt			$0	
f. Debt Service Reserve Fund			$0	
g. Other *(Specify/add rows if needed)*			$0	
SUBTOTAL		$109,550	$109,550	Calculate sum of all categories under 2.
3. Working Capital Startup Costs			$0	Start up costs are costs incurred before opening a facility or new service that under generally accepted accounting principles are not chargeable as operating expense or maintenance
TOTAL USES OF FUNDS	$0	$1,600,405	$1,600,405	Ensure that TOTAL USES OF FUNDS includes TOTAL CAPITAL COSTS, SUBTOTAL under A 2., and Working Capital Startup Costs
B. Sources of Funds				
1. Cash		$1,600,405	$1,600,405	
2. Philanthropy (to date and expected)			$0	Identify and explain the sources, plans, and the hospital's experience regarding fundraising goals under the response to the Viability standard in Section XX of the CON application
3. Authorized Bonds			$0	
4. Interest income from bond proceeds listed in #3			$0	
5. Mortgage			$0	
6. Working Capital Loans			$0	
7. Grants or Appropriations				
a. Federal			$0	
b. State			$0	
c. Local			$0	
8. Other *(Specify/add rows if needed)*			$0	Include the value of any donated land for the project in this category
TOTAL SOURCES OF FUNDS		$1,600,405	$1,600,405	Calculate sum of all categories under B. Note that TOTAL SOURCES OF FUNDS should match TOTAL USES OF FUNDS
Annual Lease Costs (if applicable)				
1. Land			$0	
2. Building			$0	
3. Major Movable Equipment			$0	
4. Minor Movable Equipment			$0	
5. Other *(Specify/add rows if needed)*			$0	

Describe the terms of the lease(s) below, including information on the fair market value of the item(s), and the number of years, annual cost, and the interest rate for the lease.

TABLE L. MANPOWER INFORMATION

INSTRUCTION: List the facility's existing staffing and changes required by this project. Include all major job categories under each heading provided in the table. The number of Full Time Equivalents (FTEs) should be calculated on the basis of 2,080 paid hours per year equals one FTE. In an attachment to the application, explain any factor used in converting paid hours to worked hours. Please ensure that the projections in this table are consistent with expenses provided in uninflated projections in Tables G and J. See additional instruction in the column to the right of the table.

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) *		
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table J)*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Total Cost** *(should be consistent with projections in Table G)*	*Additional Instruction*
1. Regular Employees												
Administration *(List general categories, add rows if needed)*												
Director	1.0	$161,400	$161,400							1.0	$161,400	
Assistant Director	1.0	$138,500	$138,500							1.0	$138,500	
Central Sterile Manager	1.0	$102,100	$102,100							1.0	$102,100	
Project Coordinator	1.0	$59,100	$59,100							1.0	$59,100	
Receptionist	3.0	$54,320	$162,960							3.0	$162,960	
Total Administration	7.0		$624,060							7.0	$624,060	*Calculate the sum of Administration*
Direct Care Staff *(List general categories, add rows if needed)*												
RNs	19.8	$99,028	$1,960,754	0.5	$99,028	$49,514				20.3	$2,010,268	
Surgical Tech	2.6	$55,993	$145,582	0.5	$55,993	$27,997				3.1	$173,578	
RNFA	2.4	$90,940	$218,256	0.5	$90,940	$45,470				2.9	$263,726	
Orderly	4.6	$40,272	$185,251							4.6	$185,251	
Anesthesia Tech	2.4	$52,354	$125,650	0.5	$52,354	$26,177				2.9	$151,827	
Backfill (all combined)	5.5	$77,152	$424,336							5.5	$424,336	
Backfill (RN only)				0.5	$99,028	$49,514				0.5	$49,514	
Total Direct Care	37.3		$3,059,829	2.5		$198,672				39.8	$3,258,501	*Calculate the sum of Direct Care*
Support Staff *(List general categories, add rows if needed)*												
CSP Lead Tech	1.0	$54,645	$54,645							1.0	$54,645	
CS Tech	4.8	$42,768	$205,277							4.8	$205,277	
Total Support	5.8		$259,922							5.8	$259,922	*Calculate the sum of Administration Support Staff*
REGULAR EMPLOYEES TOTAL	**56.1**		$3,943,811							52.6	$4,142,482	*Calculate the sum of Administration, Direct Care, and Support Staff*
2. Contractual Employees												
Administration *(List general categories, add rows if needed)*												
Total Administration												*Calculate the sum of Administration*
Direct Care Staff *(List general categories, add rows if needed)*												
Total Direct Care Staff												*Calculate the sum of Direct Care*
Support Staff *(List general categories, add rows if needed)*												
Total Support Staff												*Calculate the sum of Administration Support Staff*
CONTRACTUAL EMPLOYEES TOTAL												***Calculate** the sum of Administration, Direct Care, and Support Staff*
Benefits *(State method of calculating benefits below):*												
Benefits = 46% of total salary												*Include the method of calculating benefits in green* **bold** *at far left*
TOTAL COST	**56.1**		**$3,757,964**	**2.5**		**$198,668**	**0.0**		**$0**		**$4,648,824**	*Ensure that the sums and Total Cost of Regular Employees Total and Contractual Employee are correct*