KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc

January 3, 2017

Ruby Potter
Health Facilities Coordinator
Maryland Health Care Commission
4160 Patterson Ave.
Baltimore MD 21215

Re: Certificate of Need Application to Add One Operating Room to an Existing Freestanding Ambulatory Surgical Facility in Montgomery 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 Gaithersburg Medical Center in Montgomery County, Maryland.

A Letter of Intent was filed with the Maryland Health Care Commission (MHCC) on November 4, 2016. Thank you for your favorable consideration of this application

Sincerely,

Joseph T. Butz, Esq.
Chief Operations Officer & Vice President Delivery Operations

2101 East Jefferson Street
Rockville, MD 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

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PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: **Kaiser Permanente Gaithersburg Medical Center**

Address:

655 Watkins Mill Road	**Gaithersburg**	**20879**	**Montgomery**
Street	City	Zip	County

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

(Exhibit 1 shows the Kaiser Permanente Organization Chart)

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**			

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

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

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: Peter Mbugua, Senior Planning Consultant

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

Mailing Address:

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

Telephone: 301.816.6461

E-mail Address (required): **peter.mbugua@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 Health Plan of the Mid-Atlantic States

Mailing Address:
Provider Operations Practice Group | Legal Department

2101 E. Jefferson Street	7th Floor	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

C. Additional or alternate contact:

Name and Title: Michael Rogers, Executive Director, Strategic Planning & Consulting Services

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

Mailing Address:

2101 E. Jefferson Street	7th Floor	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

D. Additional or alternate contact:

Name and Title: **Andrew L. Solberg**

Company Name **A.L.S. Healthcare Consultant Services**

Mailing Address:

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

Telephone: 410-730-2662
E-mail Address (required): asolberg@earthlink.net

Fax: 410-730-6775

If company name is different than applicant briefly describe the relationship CON 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.

Project Description

Kaiser Permanente 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). KFHP is a non-profit corporation whose sole member is Kaiser Foundation Health Plan, Inc., and was formed on or about October 9, 1980. KFHP is licensed by the States of Maryland and Virginia and the District of Columbia and provides prepaid health care services, which include health insurance to approximately 660,000 Kaiser Permanente members. KFHP contracts with the Mid-Atlantic Permanente Medical Group (MAPMG), a multi-specialty group practice and local community hospitals to provide or arrange hospital and medical services for its members.

Expansion of the ambulatory surgery access represents an integral component of Kaiser's continuum of services to its members in addition to supporting expected membership growth in the region. Kaiser currently operates five existing facilities offering ambulatory medical care in Montgomery County. Two of these facilities, Gaithersburg and Kensington, are multi-specialty facilities with an ambulatory surgery center (ASC) at each site.

Kaiser purchased an existing 200,000 square foot six story medical office building in Gaithersburg in order to establish a larger, more comprehensive and highly integrated care model. 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 2009, Kaiser received CON approval to include an ASC with two ORs. In that CON application, Kaiser stated that the new ASC would also include shell space for one additional OR.

This application is to build out the shell space for the third OR. The growth in regional membership that Kaiser has experienced over the years has also translated into growth in procedures performed in Kaiser's ASCs. Figure 1 below shows the distribution of procedures by specialty, and this distribution is not expected to change with the addition of a third OR at Kaiser's Gaithersburg ASC.

Figure 1.
GAITHERSBURG ASC PROCEDURES BY SERVICE - 2014 - 2016 JULY YTD

Specialty	2014		2015		2016 JULY YTD	
	Count	Percentage	Count	Percentage	Count	Percentage
General Surgery	1232	31%	1275	22%	1007	26%
Gynecology	437	11%	935	16%	538	14%
Head and Neck	456	12%	762	13%	427	11%
Interventional Pain Management	7	0%	0	0%	0	0%
Obstetrics	5	0%	2	0%	0	0%
Orthopedics	836	21%	1391	23%	1002	25%
Plastics	450	11%	314	5%	162	4%
Podiatry	127	3%	296	5%	178	5%
Urology	410	10%	948	16%	634	16%
Total	3960		5923		3948	

Kaiser Permanente's Gaithersburg Medical Center ("GMC") includes all the functional areas required 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. The addition of an OR will not require expansion to any of the following support areas.

- Reception/Lounge: Patient check in and family waiting area
- Preoperative and Postoperative Area: Preparation for surgery, interviews with RN, Surgeon and Anesthesiologist administration of preoperative medications. Postoperative area for recovery and observation until stable for discharge. The ASC includes 13 bays that can be used for either pre or post-op cases.
- 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
- Administrative Spaces: Offices and administrative space for management and operations

Construction activities within an operational surgical suite must take special precautions to ensure safety and to eliminate disruption to critical patient care and treatment. A

construction plan has been established that specifically identifies the hours for construction activities that have been assumed for cost estimating purposes. Due to current workload the facility will not be able to reduce hours of operation for construction. Workers will arrive on-site at 8:00 PM each weekday evening and be allowed to set-up for 30 minutes. Actual work is not to start until 8:30 PM. Weekend work will occur 8:00 PM Friday to 3:00 AM Monday. The PACU will be completely empty of cases by 8:30 PM and patients arrive at 6:00 AM for their procedure.

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.

Applicant Response:

This requirement is not applicable to this project.

11. REQUIRED APPROVALS AND SITE CONTROL

A. Site size: ___7___ 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 _____2_____ months from capital obligation.
C. Pre-Licensure/First Use _____7_____ 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.

Applicant Response:

Please see Exhibit 2.

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.).

Applicant Response:

Table E is shown in Exhibit 11.

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.

   Joseph T. Butz, Chief Operations Officer & Vice President, Delivery System Operations, 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.
   Sentara Healthcare, 6015 Poplar Hall Drive, Norfolk, VA 20502 (April 2008 – Feb 2015)

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.

12/29/2016
Date

Signature of Owner or Board-designated Official
Chief Operations Office & Vice President,
Delivery System Operations
Position/Title
Joseph T. Butz
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:

Gaithersburg Medical Center ("GMC") provides to the public information on the range and types of services provided. However, Kaiser is an HMO, serving primarily Kaiser members and consequently, 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 GMC will be covered completely by KFHP and will be funded from Kaiser's health plan revenue. Unlike non-HMO facilities GMC will not directly bill members or insurance

[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

companies for services rendered (this excludes Medicare). Any bills for services would come from Kaiser and not GMC itself, and Kaiser would collect any revenues from GMC services.

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.

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 Surgery Centers (ASC) will be staffed exclusively by physicians from this medical group. KP's facilities exist primarily to serve KP members and are required to meet regulatory access requirements for those 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 Kaiser's 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 Kaiser's 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 2015, Kaiser invested $23,938,952 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

3,400 children in the Mid-Atlantic Region were able to rely upon Kaiser Permanente as their medical home as of August 2016, giving Kaiser's communities' most vulnerable members access to quality medical care. In 2015, Kaiser spent $4,768,380 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 3. Kaiser posts information about its MFA Program on its website, kp.org. A copy of the web site information brochure is attached as Exhibit 4. An application for MFA also appears on Kaiser's 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 2015, the total operating expenses for Kaiser Permanente Mid-Atlantic Region were $3,076,877,324. As outlined above, two of Kaiser's charitable programs (CHAP and MCCP) totaled $28,707,332 in 2015. This represents 0.9% of total operating expenses, exceeding the required threshold of 0.46% set by MHCC.

Standard .05(A)(3) – Quality of Care.

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.

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:

GMC is in compliance with the conditions of participation of the Medicare/Medicaid programs. GMC is accredited by the Accreditation Association for Ambulatory Health Care, Inc. and is also licensed and in good standing by the Maryland Department of Health and Mental Hygiene. Evidence of compliance and licensure are provided in Exhibit 5.

Standard .05(A)(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.

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:

GMC has a patient transfer agreement with Adventist HealthCare Shady Grove Medical Center, formerly known as Shady Grove Adventist Hospital. A copy of this agreement is provided in Exhibit 6.

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

Standard .05(B)(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:

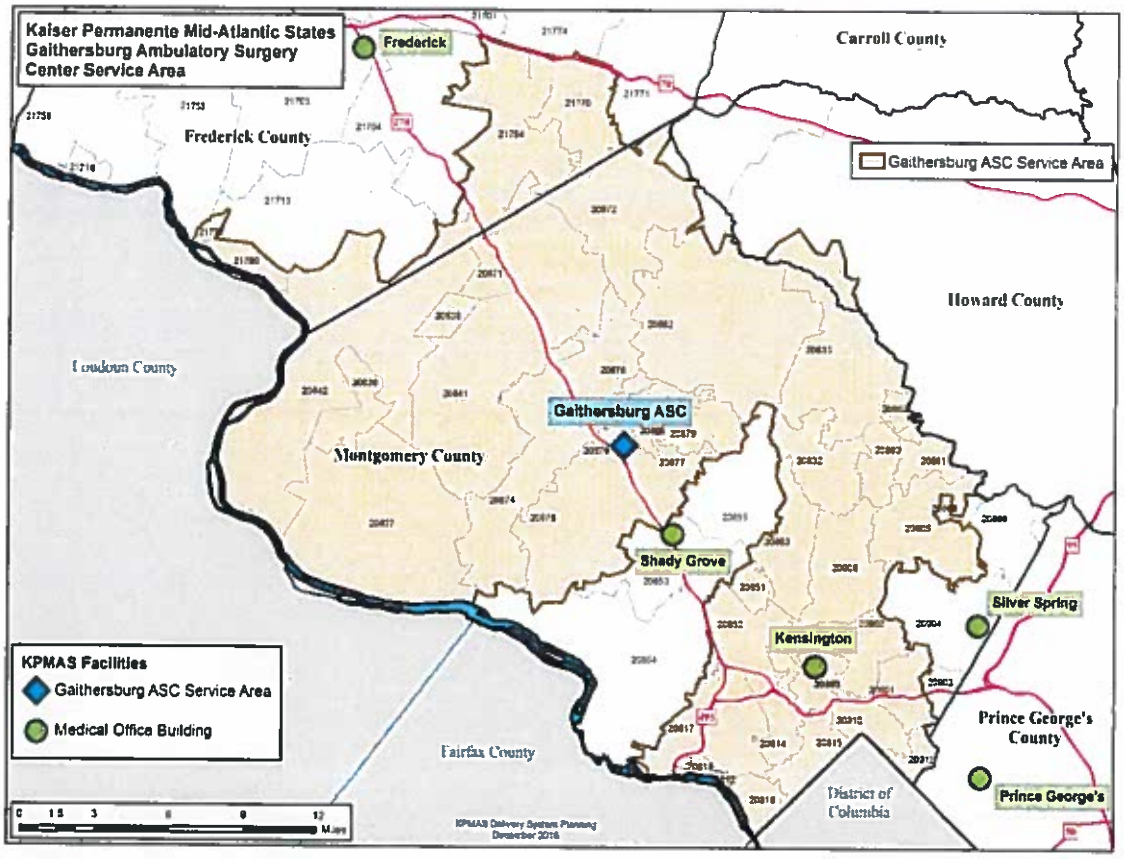
GMC's ASC service area is predominantly comprised of Montgomery County and parts of Frederick County based on the origination of members served. The specific zip codes are listed below in Figure 2, in addition to being depicted on the map in Figure 3.

Figure 2.
GMC Service Area Zip Codes

Zip Code	City	County
21754	Ijamsville	Frederick County
21770	Monrovia	Frederick County
21777	Point of Rocks	Frederick County
21790	Tuscarora	Frederick County
20812	Glen Echo	Montgomery County
20814	Bethesda	Montgomery County
20815	Chevy Chase	Montgomery County
20816	Bethesda	Montgomery County
20817	Bethesda	Montgomery County
20818	Cabin John	Montgomery County
20832	Olney	Montgomery County
20833	Brookville	Montgomery County
20837	Poolesville	Montgomery County
20838	Barnesville	Montgomery County
20839	Beallsville	Montgomery County
20841	Boyds	Montgomery County
20842	Dickerson	Montgomery County
20851	Rockville	Montgomery County
20852	Rockville	Montgomery County
20853	Rockville	Montgomery County

Zip Code	City	County
20860	Sandy Spring	Montgomery County
20861	Ashton	Montgomery County
20862	Brinklow	Montgomery County
20871	Clarksburg	Montgomery County
20872	Damascus	Montgomery County
20874	Germantown	Montgomery County
20876	Germantown	Montgomery County
20877	Gaithersburg	Montgomery County
20878	Gaithersburg	Montgomery County
20879	Gaithersburg	Montgomery County
20882	Gaithersburg	Montgomery County
20886	Montgomery Village	Montgomery County
20895	Kensington	Montgomery County
20896	Garrett Park	Montgomery County
20901	Silver Spring	Montgomery County
20902	Silver Spring	Montgomery County
20905	Silver Spring	Montgomery County
20906	Silver Spring	Montgomery County
20910	Silver Spring	Montgomery County
20912	Takoma Park	Montgomery County

Figure 3.
Gaithersburg ASC current service area



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

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**

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

Applicant Response:

This standard does not apply to this project.

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

Applicant Response:

GMC has seen robust volume growth since opening in 2012. As part of a commitment to high quality of care, Kaiser Permanente provides a high level of integrated care in Kaiser's facilities. This effort has internalized orthopedic fractures, kidney stones, vaginal hysterectomy, thyroid and total joint cases which has contributed to regional volume growth. Figure 4 shows that GMC needed 2.52 ORs to meet demand in 2015. GMC has accommodated the excessive volumes by operating longer hours than the MHCC (and KP) believes are optimal. OR capacity needs beyond 2015 are based on the projected growth in members within the Gaithersburg ASC service area and continued focused on a comprehensive, highly integrated model of care.

Figure 4.
Surgical Cases, Minutes, and OR Need
2014 – 2020

	CY	Cases	Hours/Case	Case Minutes	TAT @ 25 Mins/Case	Total Mins	Capacity/OR	ORs Needed
Actual	2014	1,845	1.43	158,301	46,125	204,426	97,920	2.09
Actual	2015	2,228	1.43	191,162	55,700	246,862	97,920	2.52
Projected	2016	2,378	1.41	195,472	59,450	254,922	97,920	2.60
Projected	2017	2,567	1.37	211,007	64,175	275,182	97,920	2.81
Projected	2018	2,707	1.37	222,515	67,675	290,190	97,920	2.96
Projected	2019	2,808	1.37	230,818	70,200	301,018	97,920	3.07
Projected	2020	2,934	1.37	241,175	73,350	314,525	97,920	3.21

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 third OR at GMC will be designed in compliance with Section 3.7 of the 2010 FGI Guidelines for Design and Construction of Healthcare Facilities currently enforced by the State of Maryland. Exhibit 7 is a letter from Adrian Hagerty of ARRAY Architects, the architectural firm commissioned 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 within in the facility. Pathology services is also provided by Kaiser. Kaiser Mid-Atlantic operates a regionally centralized pathology service, located in Rockville.

Standard .05B(6) – <u>Patient Safety.</u>

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 GMC 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 leverage 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. GMC 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) – <u>Construction Costs.</u>

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.

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		6
Perimeter		100
Height of Ceiling		14.00
Square Feet		520
f.1	Average floor Area	520.00
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		1.35016
	Product	$498.28
Height Multiplier (plus/minus from 12')		1.046
	Product	$521.20
Multi-story Multiplier (0.5%/story above 3)		1.015
	Product	$529.02
D. Sprinklers		
	Sprinkler Amount	-
Subtotal		$529.02
E. Update/Location Multipliers		
Update Multiplier		1.02
	Product	$539.60
Location Multipier		1.07
	Product	$577.37
Final Square Foot Cost Benchmark		**$577.37**

Adjustment for Renovation Only	
Departmental Cost Differential Factor for ORs	1.89
Departmental Cost Differential Factor for Shell Space	50%
Final Square Foot Cost Benchmark	**$545.61**

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. Kaiser used an approach that the MHCC Staff used in the MHCC Decision on Massachusetts Avenue Surgery Center (Matter No. 16-15-2378) and which Staff directed us to use at the Pre-Application Conference.

II. Cost of Renovation

A. Base Calculations	**Actual**	**Per Sq. Foot**
New Construction	$600,000	$1,153.85
Fixed Equipment	In Building	
Site Preparation	$0	$0.00
Architectual Fees	$120,000	$230.77
Capitalized Construction Interest	$0	$0.00
Permits	$49,556	$95.30
Subtotal	$769,556	$1,479.92

	Project Costs	**Associated A/E Fees**	**Total**
Nightime Work Cost Premium	$45,000		**$45,000**
Pre-Construction Risk Assessment (PCRA) and Interim Life Safety Measures (ILSM)	$43,500		**$43,500**
Terminal Cleaning Services	$138,000		**$138,000**
Total Cost Adjustments			**$226,500**
Per Square Foot			**$436**
C. Adjusted Project Cost	$543,056		
Per square foot	$1,044.34		

Construction activities within an operational surgical suite must take special precautions

to ensure safety and to eliminate disruption to critical patient care and treatment. A construction plan has been established that specifically identifies the hours for construction activities that have been assumed for cost estimating purposes. Due to current workload the facility will not be able to reduce hours of operation for construction. Workers will arrive on-site at 8:00 PM each weekday evening and be allowed to set-up for 30 minutes. Actual work is not to start until 8:30 PM. Weekend work will occur 8:00 PM Friday to 3:00 AM Monday. The PACU will be completely empty of cases by 8:30 PM and patients arrive at 6:00 AM for their procedure. Considering the trades will take up to 30 minutes for set-up, i.e. 8:30 PM and 30 minutes to clean-up, i.e. 2:30 AM the effective production time is six (6) hours during the week. This schedule for construction activities represents an estimated premium in the construction cost of approximately $45,000.

Additionally, preliminary Pre-Construction Risk Assessment (PCRA) and Interim Life Safety Measures (ILSM) have been prepared for the project. It has been recommended by Infection Control that terminal cleaning for the entire OR suite and Central Sterile Processing occur at the end of each day of construction. The PCRA and ILSM construction requirements represent an estimated premium of approximately $43,500 within the construction cost.

Also included within the total project cost as a separate line item is an estimated $138,000 for terminal cleaning services. This estimate was based on quotes from cleaning services and based on actual costs associated with a very similar project at the Kaiser Permanente South Baltimore Medical Center. Terminal cleaning will have to be done between the times of 3:00 AM and 6:00 AM requiring a large cleaning staff.

III. Comparison

A. Adjusted Project Cost/Sq. Ft.	$1,044.34
B. Marshall & Swift Sq. Ft. Benchmark	$545.61

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 GMC. 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:

Kaiser's response to Standard .05B(3) demonstrates that GMC's historical and projected case volume justifies the need for the additional OR to meet service area population demand.

(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:

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

(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

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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, GMC will not charge patients for the services that they obtain at GMC. Copayments and deductibles are charged by and accrue to Kaiser Foundation

Health Plan of the Mid-Atlantic States (not GMC). The expenses at GMC 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:

Kaiser's response to Standard .05B(8)(a)(iv) demonstrates that GMC's financial performance will be positive and services will benefit Kaiser's service area population.

Standard .05B(9) – Preference in Comparative Reviews.

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:

This standard does not apply to this project.

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:

Figure 5 below highlights the projected membership growth within the GMC's service area and the resulting growth in case volume that must be accommodated by the Gaithersburg ASC. As stated in Kaiser's response to Standard .05B(3) Kaiser's 2015 case volume shows the need for 2.5 ORs and that need is projected to increase.

Figure 5.
Surgical Cases and Service Area Membership
2014 – 2020

	CY	Cases	% Cases Change	Members	% Membership Change	Cases/100 members
Actual	2014	1,845		62,074		2.97
Actual	2015	2,228	20.8%	71,235	14.8%	3.13
Projected	2016	2,378	6.7%	81,165	13.9%	2.93
Projected	2017	2,567	7.9%	87,614	7.9%	2.93
Projected	2018	2,707	5.5%	92,403	5.5%	2.93
Projected	2019	2,808	3.7%	95,863	3.7%	2.93
Projected	2020	2,934	4.5%	100,156	4.5%	2.93

[(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: <u>STATISTICAL PROJECTIONS - ENTIRE FACILITY</u>

	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)	2014___	2015___	2016___	2017___	2018___	2019___	
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							
• Total Cases in ORs	1,845	2,228	2,378	2,567	2,707	2,808	
• Total Surgical Minutes in ORs**	158,759	188,228	195,553	217,423	236,186	252,382	
b. Number of Procedure Rooms (PRs)	0	0	0	0	0	0	
• Total Procedures in PRs							
• Total Cases in PRs							
• Total Minutes in PRs**							

*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 not include turnover time

10.24.01.08G(3)(c). <u>Availability of More Cost-Effective Alternatives</u>.

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:

GMC considered two alternatives:

1. Do nothing
2. Add one OR

As the response to Standard .05B(3) – Need - Minimum Utilization for Expansion of An Existing Facility demonstrates, GMC is currently operating in excess of the MHCC's (and KP's) definition of optimal utilization. We currently have two ORs running 10 hours/day (7:30 AM to 5:30 PM). The rooms are heavily utilized and have run past 5:30 PM on 97 occasions during 2016 providing surgical care to Kaiser's members. The over-utilization of the existing two ORs at GMC has resulted in members, resident in Montgomery and Frederick Counties, travelling to other Kaiser ASCs to receive care. Approximately 527 cases from Kaiser's Largo ASC were performed on members resident in these two counties in 2016.

Kaiser's quality goal is to ensure that members with (or suspected to have) a cancer diagnosis receive their surgical procedure within two weeks and orthopedic fractures are repaired within seven days of the initial injury date. By having the third OR it will allow us to maintain these Kaiser Quality standards and prove timely access to surgery without impacting previously scheduled elective cases.

Kaiser Permanente strives to provide a working environment that supports work/life balance. Due to capacity constraints, surgeons are frequently asked to operate in the evening hours as these surgeries can be unpredictable in nature. Kaiser surgeons are currently operating in the ASC past 5:30 PM and then staying to ensure the patient has recovered and is discharged safely. These extended hours of operation do not provide work/life balance for the surgeons or anesthesia providers. The current operating hours require additional supervisory and support staff (radiology, lab etc) especially when we run past Kaiser's scheduled hours. Opening the

third OR will allow for increased flexibility in managing the daily surgical schedule. With only 2 ORs, there is minimal ability to maneuver the schedule when cases are running beyond their scheduled time. This has a negative impact on not only patient satisfaction but also the satisfaction of the surgeons and employees.

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 patient satisfaction will be negatively affected.

The original CON that established GMC (Matter No. 10-03-2303) included shell space for one OR. Hence, adding one OR can be accomplished relatively quickly by fitting out the shell space.

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 8. These statements demonstrate that Kaiser has adequate funds to make the cash contribution listed in the Sources of Funds in the Project Budget. While the audited financial statements show a net loss for the Region, Exhibit 9 shows the organization's strategic plan to reverse this trend and start generating cash from operations. These projections are based on the Region's long-term strategy to increase revenue through membership growth and reduce the expense trend over time.

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

Members receiving care at the ASC come from a wide variety of primary care centers. The membership revenue for those members is counted towards their assigned primary care center, thus making the revenue side of the equation very complicated from an accounting perspective. Costs for the ASC are directly attributed to the ASC, so there is an understanding of performance based solely on cost.

There will be no debt for this project.

Because GMC will be increasing its capacity by 50% of its current licensed capacity (adding one OR to two existing ORs), We believe 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, GMC 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	2019	2020
2. Expenses							
a. Salaries, Wages, and Professional Fees, (including fringe benefits)	$4,324,154	$4,385,533	$4,193,903	$4,319,720	$7,252,780	$7,463,704	$7,637,889
b. Contractual Services							
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation	$531,580	$505,221	$499,219	$336,771	$310,502	$300,732	$293,758
f. Project Depreciation					$221,049	$245,610	$245,610
g. Current Amortization							
h. Project Amortization							
i. Supplies	$3,692,095	$2,341,698	$2,767,367	$2,850,388	$3,941,497	$4,346,888	44,444,935
j. Other Expenses (Specify)							
k. Total Operating Expenses	$8,547,829	$7,232,452	$7,460,489	$7,506,880	$11,725,828	$12,356,934	$12,622,192
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 CON approvals 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 Gaithersburg CON was approved with the following two conditions:

1. GMC 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 GMC, 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.

In 2016 Kaiser filed a request to modify the SBCMC CON related to increased project cost. The CON modification request (Docket No. 16-03-2372) was recommended for approval on November 16, 2016.

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 volume that exists within GMC's service area. It will have no impact on payer mix, as it is intended for Kaiser Permanente members. 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 members already using GMC.

EXHIBIT 1.

Kaiser Permanente Organizational Chart

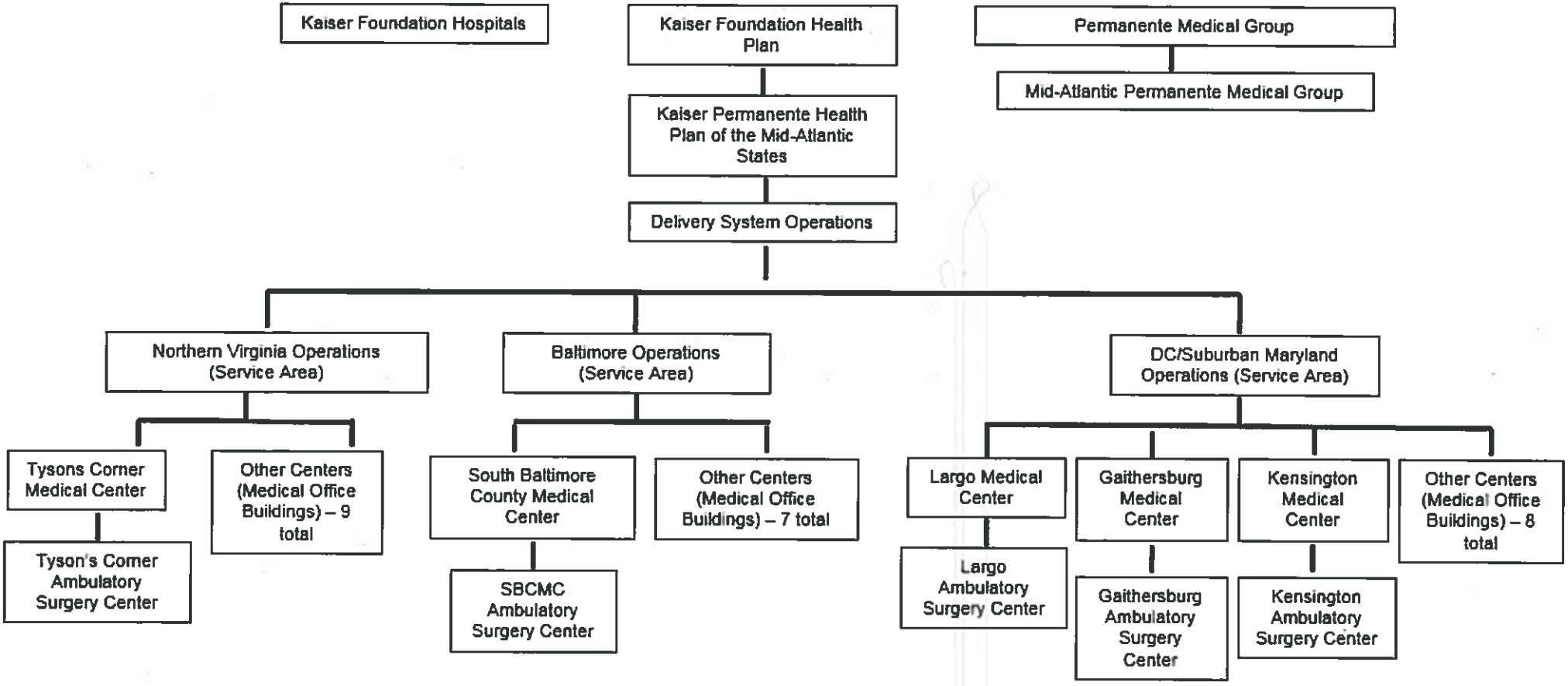


EXHIBIT 2.

Project Drawings

KAISER PERMANENTE

GAITHERSBURG MEDICAL CENTER
SURGICAL SUITE RENOVATION PROJECT

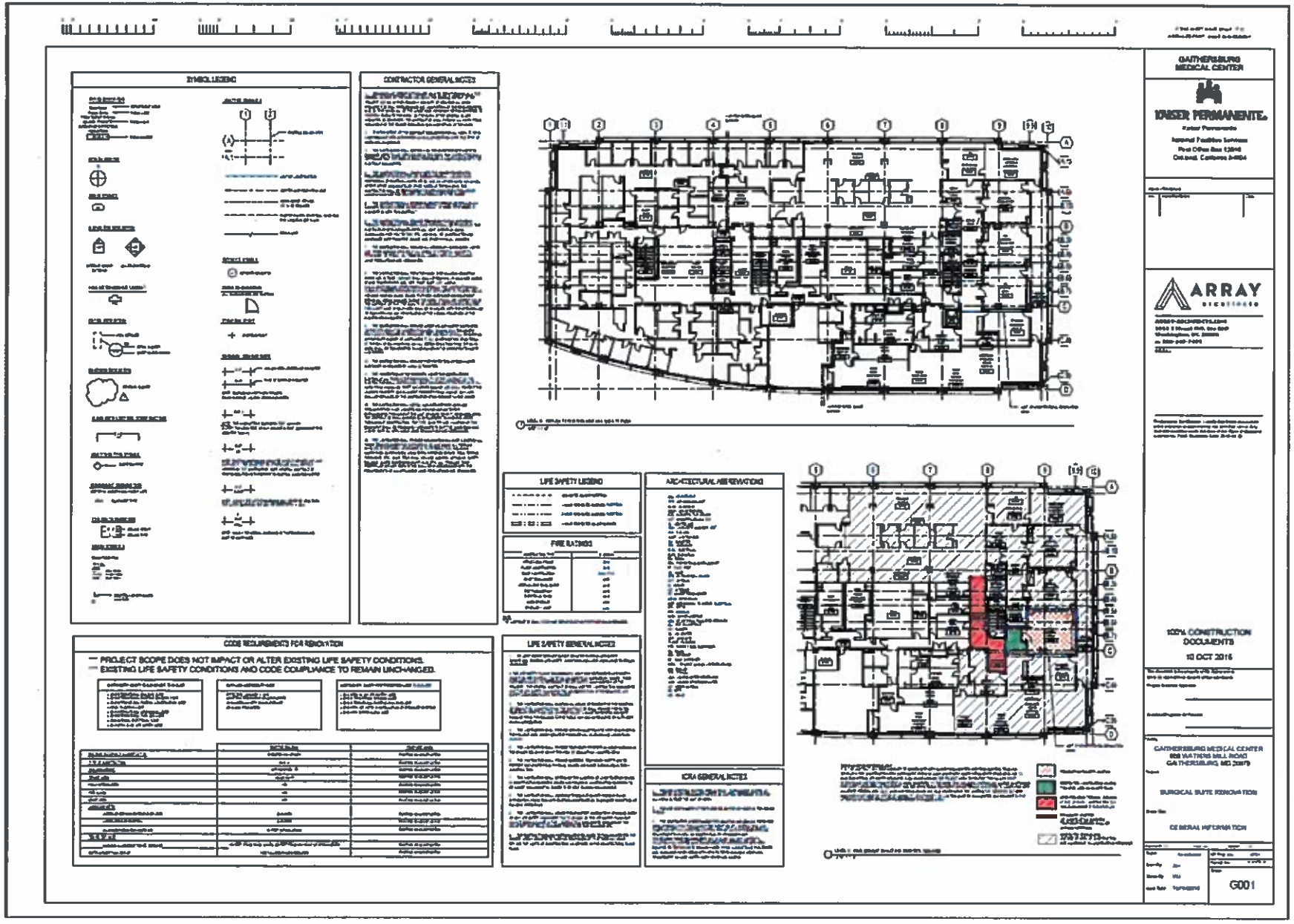
655 WATKINS MILL ROAD
GAITHERSBURG, MD 20879

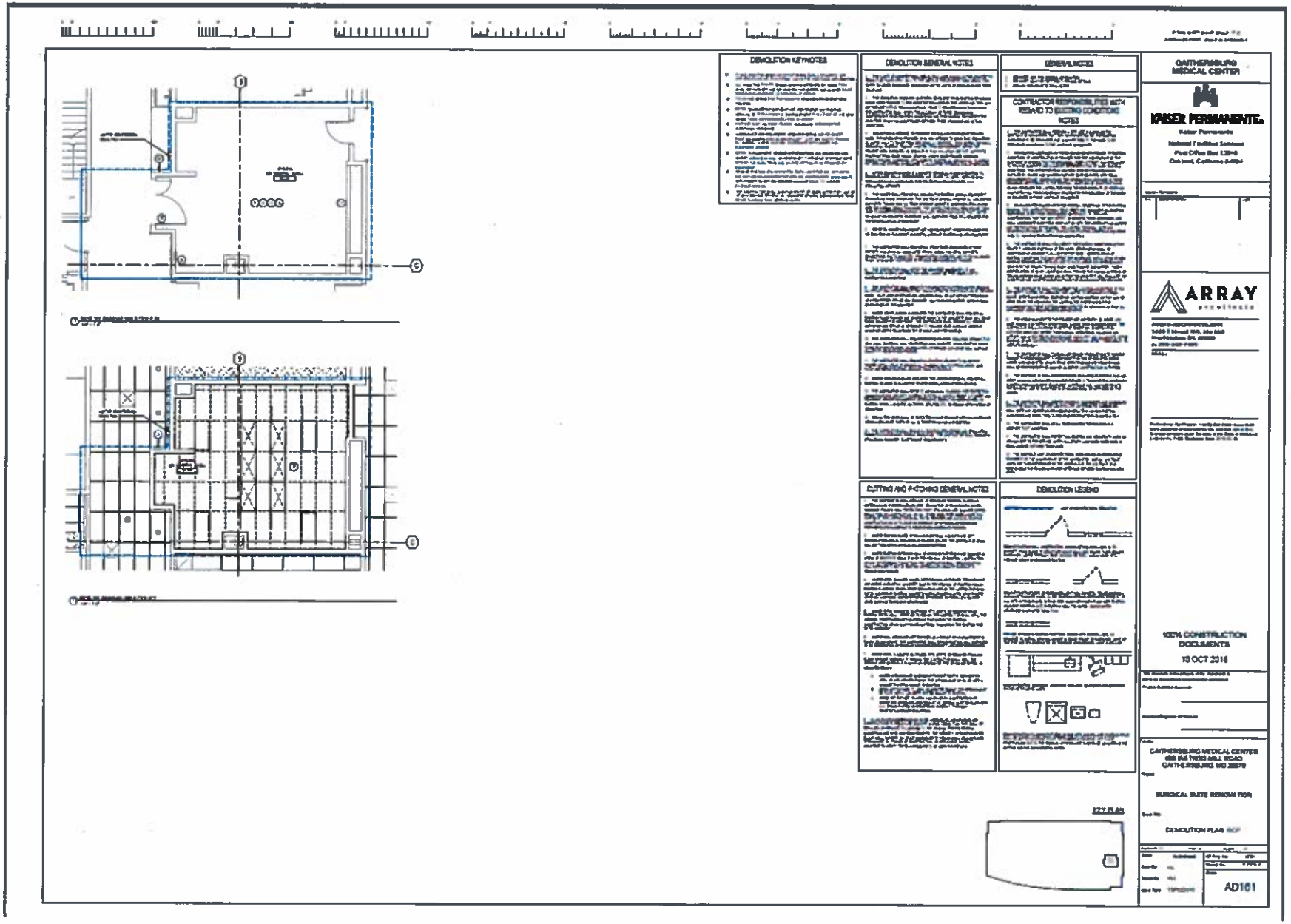
100% CONSTRUCTION DOCUMENTS

10/10/2016

OWNER	ARCHITECT	MEP ENGINEER
KAISER PERMANENTE 655 WATKINS MILL ROAD GAITHERSBURG, MD, 20879 PHONE: 844.549.2587	ARRAY ARCHITECTS 1915 I ST NW, STE 800 WASHINGTON, DC, 20006 PHONE: 202.343.3495	WHSMITH ASSOCIATES, INC. 20270 GOLDENROD LN GERMANTOWN, MD 20876 PHONE: 301.540.9068

PROJECT LOCATION PLAN


SYMBOL LEGEND
CONTRACTOR GENERAL NOTES
LIFE SAFETY LEGEND
FIRE RATINGS
ARCHITECTURAL ABBREVIATIONS
CODE REQUIREMENTS FOR RENOVATION
PROJECT SCOPE DOES NOT IMPACT OR ALTER EXISTING LIFE SAFETY CONDITIONS.
EXISTING LIFE SAFETY CONDITIONS AND CODE COMPLIANCE TO REMAIN UNCHANGED.
LIFE SAFETY GENERAL NOTES
ICRA GENERAL NOTES
GAITHERSBURG MEDICAL CENTER
KAISER PERMANENTE
ARRAY
100% CONSTRUCTION DOCUMENTS
10 OCT 2016
GAITHERSBURG MEDICAL CENTER
SURGICAL SUITE RENOVATION
GENERAL INFORMATION
G001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DEMOLITION GENERAL NOTES
GENERAL NOTES
CONTRACTOR RESPONSIBILITIES WITH REGARD TO EXISTING CONDITIONS
NOTES
CUTTING AND PATCHING GENERAL NOTES
DEMOLITION LEGEND
KEY PLAN
GAITHERSBURG MEDICAL CENTER
KAISER PERMANENTE
ARRAY
100% CONSTRUCTION DOCUMENTS
10 OCT 2016
GAITHERSBURG MEDICAL CENTER
SURGICAL SUITE RENOVATION
DEMOLITION PLAN
AD101

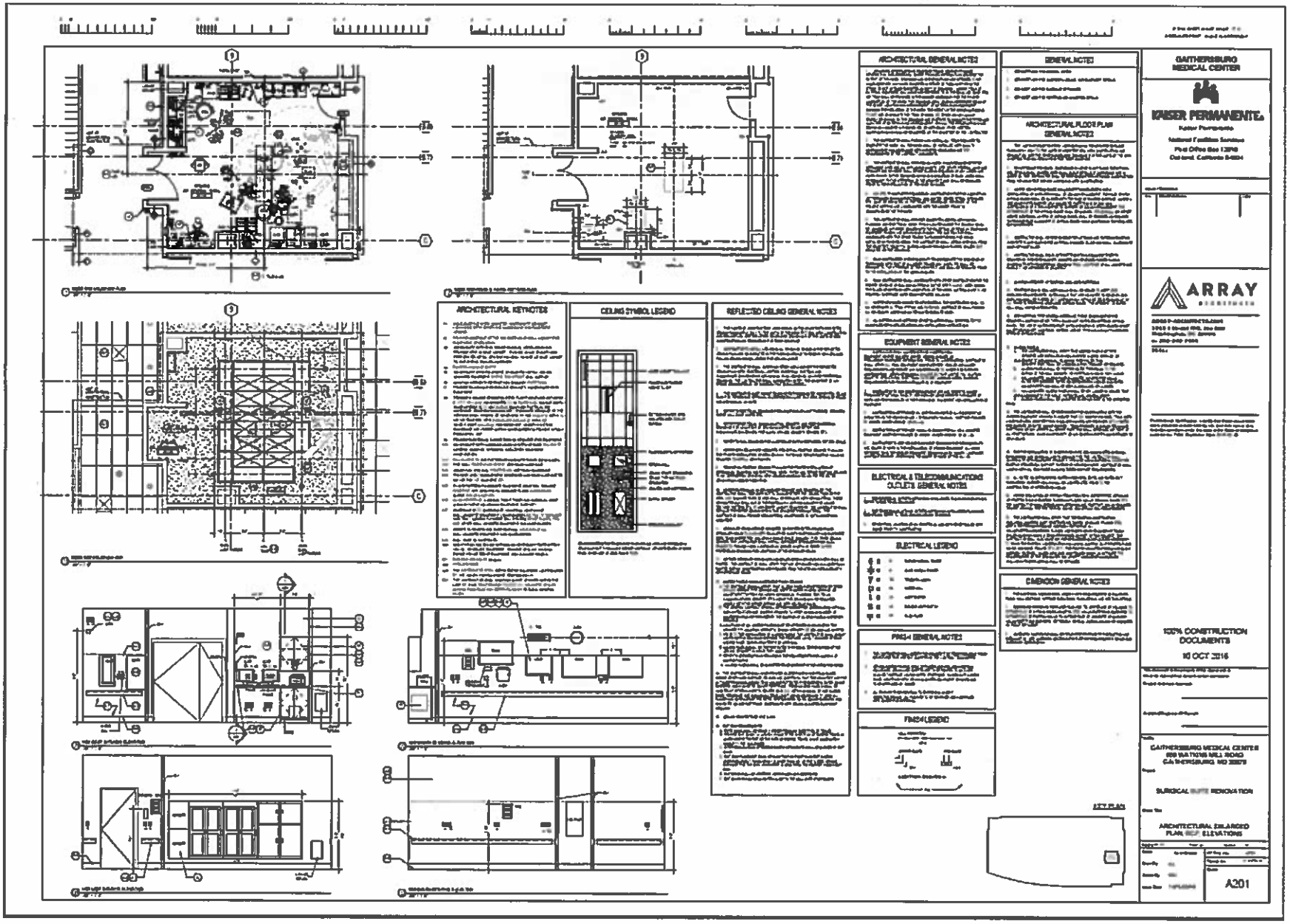
ARCHITECTURAL GENERAL NOTES
GENERAL NOTES
GAITHERSBURG MEDICAL CENTER
KAISER PERMANENTE
ARCHITECTURAL FLOOR PLAN GENERAL NOTES
EQUIPMENT GENERAL NOTES
ELECTRICAL & TELECOMMUNICATIONS OUTLETS GENERAL NOTES
ELECTRICAL LEGEND
CASEWORK GENERAL NOTES
FINISH GENERAL NOTES
FINISH LEGEND
ARCHITECTURAL KEYNOTES
CEILING SYMBOL LEGEND
REFLECTED CEILING GENERAL NOTES
ARRAY
100% CONSTRUCTION DOCUMENTS
10 OCT 2016
SURGICAL SUITE RENOVATION
ARCHITECTURAL ENLARGED PLAN, RCP, ELEVATIONS
A201

EXHIBIT 3.

Kaiser Medical Financial Assistance (MFS) Policy

KAISER PERMANENTE® National Community Benefit

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: 14 of 15

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 4.

Kaiser Medical Financial Assistance (MFS) Website Brochure

In The Community

Subsidized Care and Coverage

Medical Financial Assistance Program

Improving health care access for those with limited incomes and resources is fundamental to Kaiser Permanente's mission. Our Medical Financial Assistance program (MFA) helps low-income, uninsured, and underserved patients receive access to care. The program provides temporary financial assistance or free care to patients who receive health care services from our providers, regardless of whether they have health coverage or are uninsured. The MFA program is one of the most generous in the health care industry and is available to those patients in greatest need.

Who's Eligible for Medical Financial Assistance?

- Eligibility is based on financial need. In general, patients whose household income is at or below 200 percent, and in some regions up to 400 percent, of the federal poverty guidelines are eligible for the MFA program.
- Patients who are experiencing high medical expenses as compared to their income may be eligible under high medical expenses criteria, regardless of household income.

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.

Please note, the MFA program is not a form of health insurance and can't be used to subsidize premiums. For one example of how the program works, view this video story about the Simmons family, which received medical financial assistance after one parent and one of two children were diagnosed with Type 1 Diabetes.

How can I learn more about the Medical Financial Assistance Program and how to enroll?

To learn more about the MFA program and how to enroll, please see the program qualifications and contacts information for the Kaiser Permanente region where you live:

- Northern California
- Southern California
- Colorado
- Georgia
- Hawaii
- Virginia / Maryland / Washington DC
- Oregon / Washington

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)

EXHIBIT 5.

Accreditation Notification – Accreditation Association for Ambulatory Health Care (AAAHC)

ACCREDITATION ASSOCIATION for AMBULATORY HEALTH CARE, INC.

Congratulations!

You have been awarded a three year term of accreditation!

Your AAAHC accreditation is a significant achievement. Seeking accreditation implies a commitment to ongoing self-evaluation and continuous improvement. The dedication and effort required is substantial and I commend your staff for this approach to high-quality patient care and business practices.

Granting accreditation reflects confidence, based on evidence from this recent survey, that you meet AAAHC Standards and will continue to demonstrate the attributes of an accreditable organization. Each year of your term of accreditation, you will receive notification of release of the updated Standards. It is vital that your organization has an up-to-date copy of the *Handbook*, whether through the purchase of the annual binder, or by taking advantage of the window of opportunity to download an electronic copy free of charge.

I hope the survey experience was beneficial to your organization in identifying strengths as well as opportunities to improve, and that you found your surveyor(s) to be consultative and educational in approach.

Enclosed is your Accreditation Notification with additional details describing your award and the next steps for your organization. Your Survey Report is also enclosed. Review and use it as a periodic reference throughout your term of accreditation.

Your organization has been added to our communications mailing list. Soon you will receive our quarterly newsletter, *Triangle Times*. This publication includes news items, announcements of policy changes, review of individual Standards, and other information relevant to our accredited organizations. It will be mailed to the primary contact for your organization. You may request additional copies by providing additional names via e-mail to marketing@aaahc.org. Our e-newsletter, *Connection*, requires a subscription. It is published every other month and usually focuses on a single topic. Request a free subscription by e-mailing marketing@aaahc.org.

Again, please accept my sincere congratulations on your achievement.

Best regards,

Stephen A. Martin, Jr., Ph.D., M.P.H.

President & CEO

ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

ACCREDITATION NOTIFICATION

January 4, 2016

Organization #	99187	**Program Type**	Ambulatory Surgery Center
Organization Name	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. dba Gaithersburg Ambulatory Surgery Center		
Address	655 Watkins Mill Road,		
City | State | Zip	Gaithersburg	MD	20879-3301
Decision Recipient	Mrs. Kathy Miller, RN, MBA, MSN, CHC		
Survey Date	12/14/2015-12/15/2015	**Type of Survey**	Re-accreditation/Medicare Deemed Status
Deficiency Level 416.52	**Condition** Patient admission, assessment and discharge	**Correction Method**	Document Review, Self Attestation, Plan of Action, Follow up Survey
Accreditation Type	Full Accreditation	**Recommend Medicare Deemed Status**	Yes
Acceptable Plan of Correction Received	12/23/2015	**Correction Timeframe**	December - 2015 to January - 2016
Accreditation Term Begins	1/19/2016	**Accreditation Term Expires**	1/18/2019
Special CC:	CMS CO - Baltimore CMS RO III- Philadelphia	**CMS Certification Number (CCN)**	21C0001539
Accreditation Renewal Code	B6BAF2C499187		
Complimentary AAAHC Institute study participation code			99187FREEIQI

As an ambulatory surgery center (ASC) that has undergone the AAAHC/Medicare Deemed Status Survey, your ASC has demonstrated its compliance with the AAAHC Standards and all Medicare Conditions for Coverage (CfC). The AAAHC Accreditation Committee recommends your ASC for participation in the Medicare Deemed Status program. CMS has the final authority to determine participation in Medicare Deemed Status.

EXHIBIT 6.

Shady Grove Medical Center Transfer Agreement

PATIENT TRANSFER AGREEMENT

This Patient Transfer Agreement ("Agreement"), effective the 1st day of March, 2012, is made by and between **ADVENTIST HEALTHCARE, INC. dba SHADY GROVE ADVENTIST HOSPITAL** ("Hospital"), a _____ _____ corporation, 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 555 Watkins Mill Road, Gaithersburg, MD 20879 ("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

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:

Adventist HealthCare, Inc. dba Shady Grove Adventist Hospital
1801 Research Blvd.
Suite 200
Rockville, MD 20850

Attention: David Fontaine

If to Kaiser:

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

cc: Regional Counsel

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

ADVENTIST HEALTHCARE, INC. dba SHADY GROVE ADVENTIST HOSPITAL

By: _____
Printed Name: Jimmy Lee
Title: EVP, CFO
Date: 1/30/12

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

By: _____
Printed Name: Marilyn J. Kawamura
Title: President
Date: 1/25/12

EXHIBIT 7.

FGI Compliance Letter from Array Architects

ARRAY

Boca Raton / Boston / Cleveland / Columbus / Dallas / New York City / Philadelphia / Washington

December 5, 2016

Paul Braun
Design Manager
Kaiser Permanente National Facilities Services, Mid-Atlantic States
11921-A Bournefield Way
Silver Spring, MD 20904

RE: KAISER PERMANENTE GAITHERSBURG MEDICAL CENTER – SURGERY SUITE RENOVATION
Operating Room 3 (OR-03) Construction and Activation

Dear Paul:

On behalf of Array Architects, as commissioned by Kaiser Permanente as their design professional and agent for the subject project, I am pleased to confirm the following regarding this project, namely the surgical suite renovation project at the existing Kaiser Permanente Gaithersburg Medical Center that involves the construction and activation of one additional operating room (OR-03) at that existing facility. As the architect of record for this project and for the initial project that activated the two original operating rooms at this facility, I am pleased to confirm that the existing facility has been designed and constructed to accommodate the increased case load from the fit-out of the proposed 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,

Adrian Hagerty, AIA, LEED AP
Principal, Regional Vice President

STATE OF MARYLAND
ADRIAN HAGERTY
No. 7496
ARCHITECT

Array Architects
1819 I Street NW, Ste 801
Washington, DC 20006
202-249-7495

ARRAY-ARCHITECTS.COM

EXHIBIT 8.

2014 – 2015 KPMAS Audited Financial Statements

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

Statutory Financial Statements and Statutory Supplemental Schedules

December 31, 2015 and 2014

(With Independent Auditors' Report Thereon)

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

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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, 2015 and 2014, 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 practices 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, 2015 and 2014, 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, 2015 and 2014, 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
March 16, 2016

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

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

December 31, 2015 and 2014

(In thousands)

Admitted Assets	2015	2014
Cash and short-term investments	$ 43,246	$ 101,946
Premiums receivable - net	101,902	81,861
Health care receivables - net	20,416	26,276
Investment income due and accrued	898	891
Due from affiliated organizations	3,891	2,829
Receivables for securities	—	2,162
Amounts recoverable from reinsurers	11,843	3,165
Other receivables - net	63	136
Real estate properties occupied by Health Plan	583,638	588,591
Real estate properties held for the production of income	3,899	3,899
Property and equipment - net	134,632	142,366
Investments	244,084	242,279
Total admitted assets	$ 1,148,512	$ 1,196,401
Liabilities, Capital, and Surplus		
Liabilities:		
General expenses due or accrued	$ 28,881	$ 41,510
Reserves for unpaid claims and claims adjustment expense	104,137	95,111
Aggregate health policy reserves	46,069	—
Payroll liabilities	47,635	55,275
Payables for securities	4,281	3,161
Premiums received in advance	23,282	16,394
Ceded reinsurance premiums payable	2,540	1,162
Due to affiliated organizations	207,741	379,806
Due to associated medical group	9,250	9,453
Medicare payables and reserves	32,637	40,286
Pension and other retirement liabilities	349,443	333,263
Other liabilities	83,442	73,788
Total liabilities	$ 939,338	$ 1,049,209
Capital and surplus:		
Special surplus funds	$ 26,000	$ 24,000
Contributed capital	6,795	6,795
Surplus notes	354,000	264,000
Unassigned deficit	(177,621)	(147,603)
Total capital and surplus	209,174	147,192
Total liabilities, capital, and surplus	$ 1,148,512	$ 1,196,401

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, 2015 and 2014

(In thousands)

	2015	2014
Revenues:		
Net premium revenue	$ 2,593,585	$ 2,277,563
Medicare cost contract revenue	326,425	299,929
Other revenue	62,106	44,072
Total revenues	2,982,116	2,621,564
Medical and hospital expenses:		
Hospital and medical benefits	913,460	809,029
Other professional services	744,725	679,755
Other outside referrals	3,481	—
Emergency room and out-of-area	169,624	140,772
Other medical and hospital expenses	838,014	708,006
Net reinsurance recoveries	(16,763)	(5,461)
Total medical and hospital expenses	2,652,541	2,332,101
Claims adjustment expenses	56,236	52,172
General administrative expenses	280,013	243,339
Total expenses	2,988,790	2,627,612
Loss before other items	(6,674)	(6,048)
Net investment and other income (loss)	2,195	(1,588)
Recognized losses on investments and real estate - net	(599)	(4,700)
Statutory net loss	$ (5,078)	$ (12,336)

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, 2015 and 2014

(In thousands)

	2015	2014
Balance, beginning of year	$ 147,192	$ 176,011
Statutory net loss	(5,078)	(12,336)
Proceeds from surplus notes	90,000	131,000
Change in nonadmitted assets	(259)	(3,405)
Change in accounting principle	4,951	—
Change in pension and other retirement liabilities	(27,665)	(144,067)
Change in net unrealized gains on investments	33	(11)
Balance, end of year	$ 209,174	$ 147,192

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, 2015 and 2014

(In thousands)

	2015	2014
Cash flows from operating activities:		
Premiums and revenues collected net of reinsurance	$ 2,950,915	$ 2,570,289
Miscellaneous income	61,013	66,476
Benefits and loss related payments	(2,610,769)	(2,278,700)
Commissions, expenses, and aggregate write-ins	(348,424)	(280,367)
Net investment income	37,530	31,654
Net cash provided from operating activities	90,265	109,352
Cash flows from investing activities:		
Purchase of real property	(29,020)	(36,230)
Proceeds from investments sold, matured, or repaid	152,564	140,850
Investment purchases	(155,351)	(149,188)
Receivables/payables for securities	3,282	999
Net cash used in investing activities	(28,525)	(43,569)
Cash flows from financing and miscellaneous sources:		
Change in long-term loan from affiliate and accrued interest	—	(12,863)
Proceeds from surplus notes	90,000	131,000
Increase (decrease) in pension and other retirement liabilities	(11,485)	14,770
Net change in due from (due to) affiliated organizations	(173,127)	(101,156)
Other cash used	(25,828)	(3,446)
Net cash provided from (used in) financing and miscellaneous sources	(120,440)	28,305
Reconciliation of cash and short-term investments:		
Change in cash and short-term investments	(58,700)	94,088
Cash and short-term investments:		
Beginning of year	101,946	7,858
End of year	$ 43,246	$ 101,946
Supplemental cash flows disclosure:		
Cash paid for interest - net of capitalized amounts	$ —	$ 509
Noncash investment transactions	$ —	$ 647
Noncash real estate transfer from affiliate	$ 5,855	$ —

See accompanying notes to statutory financial statements.

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

Notes to Statutory Financial Statements

December 31, 2015 and 2014

(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 accounted for under the equity method.

At December 31, 2015 and 2014, the percentage of Health Plan's total labor force covered under collective bargaining agreements were approximately 82% and 81%, respectively. At December 31, 2015, 1% of the workforce was covered under collective bargaining agreements that are scheduled to expire within one year. At December 31, 2015, none of the workforce was working under an expired agreement, and none of the workforce is in a new bargaining unit that is currently negotiating an agreement.

Health Plan strives to improve the health and welfare of the communities it serves through its Community Benefit investment programs. Community Benefit expenditures provide funding for 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, 2015, Community Benefit expenditures (at cost, net of approximately $116.1 million of related revenues) were $100.6 million, representing 3.4% of total revenue. In comparison, for the year ended December 31, 2014, Community Benefit expenditures (at cost, net of $21.3 million of related revenues) were $81.0 million, representing 3.1% of total revenue. The calculation of Community Benefit expenditures is based on Health Plan's direct and indirect costs and the services provided by Health Plan under Community Benefit 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 March 16, 2016, 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.

Statutory accounting practices prescribed and permitted by the State of Maryland vary from U.S. generally accepted accounting principles (GAAP) in the following respects:

Nonadmitted assets: Certain assets designated as "nonadmitted," principally certain accounts receivable, property and equipment, prepaids, and other assets not specifically identified as an admitted asset, are excluded from the accompanying statutory statements of admitted assets, liabilities, capital, and surplus and are charged directly to unassigned surplus. Under GAAP, such assets are included in the balance sheets.

Investments: 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.

Medical Furniture, Fixtures, and Equipment: 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.

Statements of Cash Flow: Cash, cash equivalents, and short-term investments in the statements of cash flow represent cash balances and investments with initial maturities of one year or less. Under GAAP, the corresponding caption of cash and cash equivalents includes cash balances and investments with initial maturities of three months or less.

Presentation of Cash: Net negative cash balances are reported as a negative asset rather than as a liability under GAAP.

Co-payments: Co-payments received are netted against hospital and medical benefit expenses. Under GAAP, certain of these co-payments are recorded as revenues.

Asset Retirement Obligations: Asset retirement obligations required under GAAP are not recorded.

Real Estate: Imputed rental income and expense on the occupancy of owned buildings are recorded. Under GAAP, they are not recorded.

Insurance Recoveries: Insurance recoveries and liabilities, including reinsurance recoveries, are reported on a gross basis for GAAP, while NAIC SAP requires certain of the liabilities to be reported net of recoveries.

Bad Debt Presentation: Certain amounts for bad debts are treated as an expense. Under GAAP, certain bad debts are recorded as a reduction to the related revenue.

Health Insurance Providers Fee: The Health Insurance Providers (HIP) 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 HIP fee amount expected to be paid in the fee year. Under GAAP, no such reclassification is required.

Employee Benefits: 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. Under GAAP, the full liability and expense for these participants is required to be recorded.

Subordinated Notes: Subordinated notes are classified as capital and surplus while GAAP requires classification as debt. Also, the unapproved interest on subordinated notes is accrued under GAAP but not accrued under NAIC SAP unless meeting certain criteria.

The effects of the foregoing variances from GAAP on the accompanying statutory-basis financial statements have been determined. The GAAP net deficit for Health Plan at December 31, 2015 and 2014 was $130.7 million and $141.4 million, respectively. Health Plan's GAAP net loss for the years ended December 31, 2015 and 2014 was $7.7 million and $4.3 million, respectively.

For the years ended December 31, 2015 and 2014, 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):

	2015	2014
Cash	$ 35,553	$ 98,656
Short-term investments	7,693	3,290
Cash and short-term investments	$ 43,246	$ 101,946

(c) *Premiums and Health Care Receivables - net*

Premiums and health care receivables - net exclude nonadmitted balances. Certain receivables are not admissible in accordance with the NAIC SAP. For the year ended December 31, 2015, Health Plan changed the methodologies of accounting for premium bad debt allowances and non-admittance of related balances. Health Plan previously recorded bad debt allowances against premium receivables and calculated additional non-admitted balances over 90 days that were in excess of the amounts reserved. Health Plan now starts this calculation by non-admitting premium balances over 90 days, and then proceeds by non-admitting any remaining receivables considered to be uncollectible. Health

Plan also changed its methodology for non-admitting certain premium receivables. When group premiums are greater than 90 days past due or more than a de minimus portion of the entire balance is outstanding, the entire amount is non-admitted. When individual premiums have more than one payment past due, the entire balance is non-admitted. The changes in methodologies continue to comply with statutory accounting guidance and align the Health Plan with other Kaiser Health Plans. The changes resulted in a $3.0 million increase to expense related to removing the current year allowance, and a $922 thousand increase to non-admitted premium receivables, offset by a $5.0 million increase to surplus related to the prior year premium bad debt allowance. The cumulative effect to capital and surplus as of and for the twelve months ended December 31, 2015 was a net increase of $1.1 million.

(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, 2015 and 2014, real estate, property, and equipment included in the statement of admitted assets, liabilities, capital, and surplus were net of encumbrances of $10.4 million and $9.5 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 scientific 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, 2015 and 2014, $792 thousand and $806 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 is conducted by the government.

(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 administrative 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, 2015 and 2014, 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, Medicaid 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, 2015 and 2014, the amount of premiums written by Health Plan subject to the retrospective rating feature were $57.2 million and $52.1 million, respectively. During both 2015 and 2014, revenue derived under these contracts was 2.0% of total premiums written. During 2015 and 2014, retrospective premium adjustments under these contracts were $(3.3) million and $(1.9) 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, 2015 and 2014, in connection with Health Plan's Medicare cost contract, Health Plan recorded allowances and reserves for adjustments of recorded revenues in the amount of $34.6 million and $33.5 million, respectively. For the years ended December 31, 2015 and 2014, Medicare revenues increased approximately $15.9 million and $14.6 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.

Health Plan provides coverage to Medicaid members in certain locations in Maryland and Virginia as a Managed Care Organization. For the years ended December 31, 2015 and 2014, revenue related to these members was $126.3 million and $24.1 million, respectively.

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 2015 and 2014 were 23.3% and 27.3%, respectively, of total revenue.

(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 a welfare plan (Health and Welfare Plan) in which multiple employers who are related parties participate. Under the terms of the Health and Welfare Plan, 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 Plan.

(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, 2015 and 2014.

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, 2015 and 2014.

The PPACA imposes a 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 assessments for 2016 and 2015 are based on the agency's calculation of the KFHP group's net premiums in the data years of 2015 and 2014, respectively, as a percentage of the total premiums for all U.S. health plans in the data year. Management determined that the 2015 assessment on Health Plan was $24.0 million and recorded the estimate of the annual assessment in January 2015. The total amount assessed to the KFHP group was paid in September 2015. Management has estimated the 2016 assessment on Health Plan to be approximately $26.0 million and will record the annual assessment in the first quarter of 2016. The 2016 assessment has been segregated and classified as special surplus funds in capital and surplus. Had such assessment been recorded as of December 31, 2015, 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 $26.0 million. A risk based capital action level would not have been triggered had the 2016 fee been recorded as of December 31, 2015.

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

	2015	2014
PPACA fee assessment payable for the upcoming year	$ 26,000	$ 24,000
PPACA fee assessment paid	24,762	17,430
Premiums written subject to PPACA assessment	2,933,341	2,578,741
Total Adjusted Capital before surplus adjustment	209,174	147,192
Total Adjusted Capital after surplus adjustment	183,174	123,192
Authorized Control Level	57,369	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 Statement Value, and other accounting practices as prescribed or permitted by the MIA requires management to make estimates and assumptions that affect the reported amounts. 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 certain amounts accrued related to the PPACA Reinsurance, Risk Adjustment, and Risk Corridors Programs represent significant estimates. Actual results could differ materially from

those estimates. 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) 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 is temporary, and 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 2015 and 2014 as expected claims reimbursements under this program. For the years ended December 31, 2015 and 2014, Health Plan has recorded $14.9 million and $5.5 million, respectively, for estimated recoveries from the Reinsurance Program. For the years ended December 31, 2015 and 2014, Health Plan has recorded $23.3 million and $28.2 million, respectively, of Reinsurance fees.

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. 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. For the years ended December 31, 2015 and 2014, Health Plan has recorded $55.6 million and $0 million, respectively, as net revenue reductions related to the Risk Adjustment Program.

The Risk Corridors Program is temporary, beginning in 2014 and continuing through 2016. This program provides for gains and losses on the individual and small group market plans. For the years ended December 31, 2015 and 2014, Health Plan has recorded $253 thousand and $0 million, respectively, as net revenue additions related to the Risk Corridors Program.

The Maryland legislature, with the intent of stabilizing premiums as certain individuals enter the insurance market from high risk pools, established a three-year transition program effective January 1, 2014. The Maryland Transitional Reinsurance Program (MTRP) provides additional funding to insurance carriers for claims above a specified level incurred by these individuals for claims not covered by the PPACA Reinsurance Program. There were no assessments in 2015 or 2014. Recoveries were $1.9 million and $0 million in 2015 and 2014, respectively.

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 2015 assessment was $3.3 million and was based on 1% of 2014 gross premiums originating from the District of Columbia. 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 March 2015, the NAIC adopted revisions to Statement of Statutory Accounting Principles (SSAP) 1, *Disclosure of Accounting Policies, Risks & Uncertainties, and Other Disclosures*. The revisions adopt Accounting Standards Update *2014-15, Presentation of Financial Statements - Going Concern* and incorporate audited disclosure requirements for a reporting entity to evaluate and disclosure whether there is substantial doubt on the entity's ability to continue as a going concern. The guidance is effective for the year ending December 31, 2016 with early adoption permitted. Management will adopt the guidance for its year end 2016 reporting and include disclosures as required.

In June 2015, the NAIC adopted revisions to SSAP 54, *Individual and Group Accident and Health Contracts and SSAP 84, Amounts Receivable Under Government Insured Plans*. The guidance was adopted prospectively by Health Plan in 2015. The revisions clarify reporting requirements for Medicare risk adjustment receivables and payables. Management reclassified certain Medicare receivables from health care receivables - net to premiums receivable - net and certain Medicare payables from other liabilities to aggregate health policy reserves during 2015. The 2014 amounts were not reclassified as of December 31, 2015.

(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 2015 and 2014, based upon the terms of the Hospital Service Agreement, Health Plan was charged $349.6 million and $314.7 million, respectively, by Hospitals. During 2015 and 2014, based upon the terms of the agreement with the Medical Group, Health Plan incurred expenses of $602.2 million and $517.7 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 amounts paid by KFHP or Hospitals on Health Plan's behalf. During 2015 and 2014, charges for costs of services provided by KFHP and Hospitals, and for amounts paid by KFHP and Hospitals on behalf of Health Plan, were $1.5 billion and $1.3 billion, respectively. During 2015 and 2014, Health Plan was charged interest expense of $1.9 million and $5.6 million, respectively, by KFHP and Hospitals, including long-term loan from affiliate.

Health Plan and its affiliates manage professional liabilities and other risks using captive risk pooling vehicles, primarily Lokahi Assurance, Ltd., a subsidiary of KFHP. During 2015 and 2014, Health Plan's premium expense under these arrangements was $20.0 million and $20.9 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, 2015 and 2014, pursuant to this contract, Health Plan recognized revenues of $4.6 million and $3.7 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 2015 and 2014, pursuant to this arrangement, Health Plan recognized $26.3 million and $25.0 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. During 2015 and 2014, net revenue recorded for services provided by Health Plan was $8.9 million and $7.8 million, respectively. During 2015 and 2014, net expense for services provided to Health Plan members was $6.3 million and $7.2 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.

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

	2015	2014
Net amounts due from (due to):		
Kaiser Foundation Health Plan, Inc.	$ (31,024)	$ (19,229)
Kaiser Foundation Hospitals	(176,380)	(359,939)
Other affiliated organizations	3,554	2,191
Total due to affiliated organizations - net	$ (203,850)	$ (376,977)
Amount due from (due to):		
Due from affiliated organizations	$ 3,891	$ 2,829
Due to affiliated organizations	(207,741)	(379,806)
Total due to affiliated organizations - net	$ (203,850)	$ (376,977)

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 $56.4 million and $51.9 million at December 31, 2015 and 2014, 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

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

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 $3.1 million and $5.7 million at December 31, 2015 and 2014, 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
3/31/2015	$ 4,548	$ 4,548	$ 4,342	$ —	$ —
6/30/2015	5,183	5,183	5,134	—	—
9/30/2015	5,874	5,874	5,637	—	—
12/31/2015	5,882	3,910	3,255	—	—

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	$ 3,583	$ 3,481	$ —	$ 102
6/30/2014	4,954	4,093	4,021	72	—
9/30/2014	5,489	6,062	5,962	100	—
12/31/2014	5,944	4,901	4,605	296	—

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	1,183	1,183	—	—
9/30/2013	1,442	1,442	1,240	202	—
12/31/2013	1,494	1,197	1,195	2	—

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

At December 31, 2015, 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	$ 908,666	$ 5,767	$ 271,865	$ 156,228	$ 14,152	$ 444,245
Amount classified as nonadmitted	(8,576)	—	(605)	(665)	(143)	(1,413)
	900,090	5,767	271,260	155,563	14,009	442,832
Accumulated depreciation and amortization	(316,452)	(1,868)	(210,503)	(84,090)	(13,607)	(308,200)
Total	$ 583,638	$ 3,899	$ 62,757	$ 71,473	$ 402	$ 134,632

For the year ended December 31, 2015, 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	$ 34,927	$ —	$ 26,051	$ 8,895	$ 1,550	$ 36,526

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

For the years ended December 31, 2015 and 2014, impairment losses of real estate properties occupied by Health Plan totaled $69 thousand and $5.1 million, 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):

2015	Aggregate fair value	Statement value	Fair value in excess of carrying value
Short-term investments:			
Money market mutual funds	$ 7,193	$ 7,193	$ —
Industrial and miscellaneous bonds	500	500	—
Total short-term investments	7,693	7,693	—
Bonds and other invested assets:			
U.S. Treasury and government-sponsored agencies	107,533	107,488	45
All other government bonds	1,116	1,116	—
Loan-backed and/or structured securities	41,402	41,321	81
Industrial and miscellaneous bonds	94,435	94,159	276
Total bonds and other invested assets	244,486	244,084	402
Total investments	$ 252,179	$ 251,777	$ 402

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

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 2015, 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	$ 6,767	$ (12)	$ 6,755
Inability or lack of intent to retain - Q2	11,379	(25)	11,354
Inability or lack of intent to retain - Q3	1,864	(7)	1,857
Inability or lack of intent to retain - Q4	31,383	(150)	31,233
Total	$ 51,393	$ (194)	$ 51,199

Each impairment of loan-backed and/or structured securities recognized during the year ended December 31, 2015 was as follows (in thousands):

CUSIP	Security description	Amortized cost before OTTI	Present value of projected cash flows	Recognized OTTI	Amortized cost after latest OTTI	Fair value at impairment date	Current period final NAIC designation	Quarter impaired
05947U2R8	BANK OF AMERICA COMMERCIAL MTG	$ 478	$ 476	$ (2)	$ 476	$ 476	1FM	Q1 2015
05947U4D7	BANK OF AMERICA COMMERCIAL MTG	1,120	1,118	(2)	1,118	1,118	1FM	Q1 2015
07387BCL3	BEAR STEARNS COMMERCIAL MORTGAGE	1,012	1,011	(1)	1,011	1,011	1FM	Q1 2015
12513EAG9	CITIGROUP/DEUTSCHE BANK COMM	957	953	(4)	953	953	1FM	Q1 2015
3137BDY67	FHLMC MULTIFAMILY STRUCTURED	307	306	(1)	306	306	1	Q1 2015
59022HMU3	MERRILL LYNCH MORTGAGE TRUST	528	527	(1)	527	527	1FM	Q1 2015
05947U4D7	BANK OF AMERICA COMMERCIAL MTG	684	683	(1)	683	683	1FM	Q1 2015
65477NAD8	NISSAN AUTO LEASE TRUST	1,300	1,299	(1)	1,299	1,299	1	Q1 2015
07387BCL3	BEAR STEARNS COMMERCIAL MORTGAGE	568	567	(1)	567	567	1FM	Q2 2015
3137BDY67	FHLMC MULTIFAMILY STRUCTURED	929	928	(1)	928	928	1	Q2 2015
36252WAU2	GS MORTGAGE SECURITIES TRUST	574	569	(5)	569	569	1FM	Q2 2015
46625YXP3	JP MORGAN CHASE COMMERCIAL MORTGAGE	421	420	(1)	420	420	1FM	Q2 2015
46641WAT4	JPMBB COMMERCIAL MORTGAGE	1,514	1,501	(13)	1,501	1,501	1FM	Q2 2015
13975KAE9	CAPITAL AUTO RECEIVABLES ASSET	740	739	(1)	739	739	1FE	Q2 2015
200474AX2	COMM MTG TR	760	759	(1)	759	759	1FM	Q2 2015
3137BBR27	GOVERNMENT NATIONAL MORTGAGE	613	612	(1)	612	612	1	Q2 2015
3137BDY67	FHLMC MULTIFAMILY STRUCTURED	866	860	(6)	860	860	1	Q3 2015
03065MAF4	AMERICREDIT AUTOMOBILE RECEIVABLE	290	288	(2)	288	288	1FE	Q4 2015
059497AX5	BANC OF AMERICA COMM MORTG INC	427	424	(3)	424	424	1FM	Q4 2015
059513AF8	BANC OF AMERICA COMMERCIAL	161	159	(2)	159	159	1FM	Q4 2015
12630DAV6	COMM MORTGAGE TRUST	201	198	(3)	198	198	1FM	Q4 2015
3136AGKH5	FANNIE MAE	472	471	(1)	471	471	1	Q4 2015
3136AGLH3	FANNIE MAE	362	361	(1)	361	361	1	Q4 2015
3136AKJ38	FANNIE MAE	527	525	(2)	525	525	1	Q4 2015
3137BDY67	FHLMC MULTIFAMILY STRUCTURED	810	806	(4)	806	806	1	Q4 2015
313973YD0	FANNIE MAE	899	895	(4)	895	895	1	Q4 2015
34530XAF2	FORD CREDIT AUTO LEASE TRUST	450	446	(4)	446	446	1FE	Q4 2015
36252WAU2	GS MORTGAGE SECURITIES TRUST	566	561	(5)	561	561	1FM	Q4 2015
380130AL3	GM FINANCIAL AUTOMOBILE LEASING	930	925	(5)	925	925	1FE	Q4 2015
46634SAB1	JP MORGAN CHASE COMMERCIAL	563	560	(3)	560	560	1FM	Q4 2015
46641JAT3	JPMBB COMMERCIAL MORTGAGE	609	604	(5)	604	604	1FM	Q4 2015
46641WAT4	JPMBB COMMERCIAL MORTGAGE	1,494	1,480	(14)	1,480	1,480	1FM	Q4 2015
58769AAD8	MERCEDES-BENZ AUTO LEASE TRUST	950	946	(4)	946	946	1FE	Q4 2015
61690UAA2	MORGAN STANLEY BAML TRUST	351	349	(2)	349	349	1FE	Q4 2015
61761DAB8	MORGAN STANLEY BAML TRUST	336	335	(1)	335	335	1FM	Q4 2015
65477PAC3	NISSAN AUTO RECEIVABLES OWNER	1,157	1,155	(2)	1,155	1,155	1FE	Q4 2015
78403DAU5	SBA TOWER TRUST	700	684	(16)	684	684	1FE	Q4 2015
02006YAD7	ALLY AUTO RECEIVABLES TRUST	1,099	1,094	(5)	1,094	1,094	1FE	Q4 2015
065604AC4	BANK OF THE WEST AUTO TRUST	730	728	(2)	728	728	1FE	Q4 2015
12592WAD0	CNH EQUIPMENT TRUST	825	820	(5)	820	820	1FE	Q4 2015
12626GAA1	COMMERCIAL MORTGAGE PASS-THROUGH	409	407	(2)	407	407	1FM	Q4 2015
12630DAU8	COMM MORTGAGE TRUST	549	547	(2)	547	547	1FM	Q4 2015
12632XAC2	CNH EQUIPMENT TRUST	688	686	(2)	686	686	1FE	Q4 2015
13975KAE9	CAPITAL AUTO RECEIVABLES ASSET	739	734	(5)	734	734	1FE	Q4 2015
200474AX2	COMM MTG TR	701	695	(6)	695	695	1FM	Q4 2015
380130AD1	GM FINANCIAL AUTOMOBILE LEASING	689	685	(4)	685	685	1FE	Q4 2015
3137BBR27	GOVERNMENT NATIONAL MORTGAGE	576	573	(3)	573	573	1	Q4 2015
46639YAL1	JP MORGAN CHASE COMMERCIAL	316	315	(1)	315	315	1FM	Q4 2015

CUSIP	Security description	Amortized cost before OTTI	Present value of projected cash flows	Recognized OTTI	Amortized cost after impairment OTTI	Fair value at impairment date	Current period final NAIC designation	Quarter impaired
46641BAA1	JP MORGAN CHASE COMMERCIAL	$ 472	$ 471	$ (1)	$ 471	$ 471	1FM	Q4 2015
46641WAS6	JPMBB COMMERCIAL MORTGAGE	454	451	(3)	451	451	1FM	Q4 2015
50116RAC0	KUBOTA CREDIT OWNER TRUST	915	909	(6)	909	909	1FE	Q4 2015
61763BAQ7	MORGAN STANLEY BAML TRUST	316	314	(2)	314	314	1FM	Q4 2015
654908AE5	NISSAN AUTO LEASE TRUST	859	856	(3)	856	856	1FE	Q4 2015
86803VAD1	SUNTRUST AUTO RECEIVABLES TRUST	940	932	(8)	932	932	1FE	Q4 2015
92890PAA2	WF-RBS COMMERCIAL MTG TRUST	333	332	(1)	332	332	1FM	Q4 2015
Various	Securities with OTTI <$1	14,156	14,150	(6)	14,150	14,150	Various	Various

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

	2015		2014	
	Statement value	Estimated fair value	Statement value	Estimated fair value
Due in one year or less	$ 11,046	$ 11,062	$ 17,412	$ 17,457
Due after one year through five years	199,410	199,715	180,091	180,901
Due after five years through ten years	—	—	1,760	1,767
Loan-backed and or structured securities	41,321	41,402	46,306	46,497
	$ 251,777	$ 252,179	$ 245,569	$ 246,622

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):

	2015	2014
Interest and other investment income	$ 55,920	$ 53,509
Interest and other investment expense	(53,725)	(55,097)
Total net investment and other income (loss)	$ 2,195	$ (1,588)

For the years ended December 31, 2015 and 2014, 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, 2015 and 2014, the OTTI totaled $1.1 million and $426 thousand, respectively.

For the years ended December 31, 2015 and 2014, rental income related to administrative and health delivery owned buildings was $51.9 million and $50.2 million, respectively. These amounts are reflected as interest and other investment income in the above table.

During 2015, Health Plan sold, redeemed, or otherwise disposed of short and long-term investments for $223.0 million and realized gross gains of $563 thousand and gross losses of $101 thousand. 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.

(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, 2015 and 2014, the estimated salvage and subrogation included as a reduction to unpaid claims and claims adjustment expense was $337 thousand and $339 thousand, respectively. At December 31, 2015 and 2014, the estimated reinsurance recoveries under the PPACA and MTRP included as a reduction to reserves for unpaid claims and claims adjustment expense was $2.4 million and $2.3 million, respectively.

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):

	2015	2014
Balances at January 1	$ 95,111	$ 78,296
Incurred related to:		
Current year	2,665,215	2,339,486
Prior years	(12,674)	(7,385)
Total incurred	2,652,541	2,332,101
Paid related to:		
Current year	2,563,956	2,246,459
Prior years	79,559	68,827
Total paid	2,643,515	2,315,286
Balances at December 31	$ 104,137	$ 95,111

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, 2015 and 2014, substantially all pension fund assets were held in a group trust. At December 31, 2015 and 2014, the trust's assets were invested primarily in fixed-income and equity securities, with approximately 22% and 18% 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):

	2015	2014
Change in projected benefit obligation (PBO):		
Benefit obligation at beginning of year	$ 16,361	$ 12,964
Service cost	1,130	879
Interest cost	713	646
Plan amendments	118	1
Net actuarial loss (gain)	(1,137)	2,567
Benefits paid	(649)	(696)
Benefit obligation at end of year	$ 16,536	$ 16,361
Accumulated benefit obligation (ABO) at end of year	$ 12,846	$ 12,453
Change in KFHP's, Hospitals', and their subsidiaries' share of trust assets:		
Fair value of plan assets at beginning of year	$ 9,374	$ 8,503
Actual return on plan assets	(165)	627
Contributions	1,589	940
Benefits paid	(649)	(696)
Fair value of plan assets at end of year	10,149	9,374
Funded status	$ (6,387)	$ (6,987)

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):

	2015	2014
Funded status allocated to Health Plan	$ (304,629)	$ (333,493)
Liabilities recognized consist of:		
Accrued benefit cost	$ (65,670)	$ (65,887)
Liability for pension benefits	(223,513)	(215,535)
	$ (289,183)	$ (281,422)
Amounts recognized in unassigned surplus that have not been recognized as components of net periodic pension cost:		
Net actuarial loss	$ 238,959	$ 265,371
Prior service cost	—	2,235
	238,959	267,606
Unrecognized transition liability	(15,446)	(52,071)
Net amounts recognized in unassigned surplus	$ 223,513	$ 215,535

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

	2015	2014
Service cost	$ 56,239	$ 43,085
Interest cost	34,078	30,531
Expected return on plan assets	(33,619)	(30,172)
Amortization of net actuarial loss	17,357	6,183
Amortization of prior service cost	2,235	5,547
Net pension expense	76,290	55,174
Other changes in plan assets and benefit obligations recognized in capital and surplus:		
Transition liability recognized	36,625	27,570
Net actuarial loss (gain)	(9,055)	110,932
Amortization of net actuarial loss	(17,357)	(6,183)
Amortization of prior service cost	(2,235)	(5,547)
Total recognized in surplus	7,978	126,772
Total recognized in net periodic benefit cost and surplus	$ 84,268	$ 181,946

During 2016, $12.5 million of net actuarial loss will be amortized from unassigned funds into net pension expense.

At December 31, 2015, 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	$ 19,592
Amount to establish liability equal to the unfunded ABO	$ —
Unrecognized transition liability at December 31, 2014	$ (52,071)
Transition liability recognized	27,570
Additional transition liability recognized due to net actuarial gain and plan amendments	9,055
Total transition liability recognized during 2015	36,625
Unrecognized transition liability at December 31, 2015	$ (15,446)

Health Plan will recognize $15.4 million as a reduction to surplus during 2016.

Actuarial assumptions used were as follows:

	2015	2014
Weighted average discount rate at January 1 for calculating pension expense	4.25%	5.15%
Weighted average discount rate for calculating December 31 PBO	4.70%	4.25%
Weighted average salary scale for calculating pension expense and December 31 PBO	4.20%	4.20%
Expected long-term rate of return on plan assets for calculating pension expense	7.25%	7.25%

During 2016, Health Plan expects to contribute approximately $49.6 million to the Plan.

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

2016	$ 31,200
2017	34,700
2018	38,900
2019	42,900
2020	47,300
2021 - 2025	288,700

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, 2015, 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	$ 110	$ 1,082	$ —	$ 1,192
Broker receivables	—	156	—	156
Securities lending collateral	—	1,332	—	1,332
U.S. equity securities	4,219	365	—	4,584
Foreign equity securities	4,125	1,616	—	5,741
Global equity funds	—	187	—	187
Debt securities issued by the U.S. government	—	841	—	841
Debt securities issued by U.S. government corporations and agencies	—	70	—	70
Debt securities issued by U.S. states and political subdivisions of states	—	199	—	199
Foreign government debt securities	—	486	—	486
U.S. corporate debt securities	—	3,722	—	3,722
Non-U.S. corporate debt securities	—	957	—	957
U.S. agency mortgage-backed securities	—	159	—	159
Non-U.S. agency mortgage-backed securities	—	40	—	40
Other	1	569	—	570
Alternative investments:				
Absolute return	—	900	1,249	2,149
Private equity	—	—	2,339	2,339
Risk parity	—	—	597	597
Total assets	8,455	12,681	4,185	25,321
Liabilities:				
Broker payables	—	282	—	282
Securities lending payable	—	1,332	—	1,332
Other liabilities	12	117	—	129
Total liabilities	12	1,731	—	1,743
Fair value of pension trust assets - net	$ 8,443	$ 10,950	$ 4,185	$ 23,578

At December 31, 2015, KFHP's, Hospitals', and their subsidiaries' share of pension trust assets was 43.0%, or $10.1 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, 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.

For the year ended December 31, 2015, the reconciliation of assets with fair value measurements using significant unobservable inputs (level 3) was as follows (in millions):

	Alternative investments
Beginning balance	$ 3,103
Transfers into level 3	—
Changes related to actual return on plan assets	22
Purchases, sales, and settlements - net	1,060
Ending balance	$ 4,185
Total year-to-date net gains related to assets held at December 31, 2015	$ 21

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

During the years ended December 31, 2015 and 2014, 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:

	2015 and 2014 target range	2015 and 2014 ELTRA
Cash and cash equivalents	0%-3%	3.00%
Equity securities	43%-55%	8.65%
Debt securities	28%-45%	5.50%
Alternative investments	10%-25%	7.60%
Total	100%	7.25%

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, 2015, the trust had original commitments related to alternative investments of $5.4 billion, of which $2.4 billion was invested, leaving $3.0 billion of remaining commitments. 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.

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 and risk parity investments of $663 million are subject to lock-up periods of up to 3 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.

Certain debt and equity investment funds have a redemption period of greater than 10 days. Debt and equity investment funds of $1.4 billion are redeemable between 10 and 30 days. Equity investment funds of $149 million have a redemption period of up to 120 days.

Health Plan Allocations

Health Plan's 2015 contributions made, benefits paid, PBO, ABO, and fair value of allocated plan assets were $76.5 million, $31.0 million, $790.2 million, $613.9 million, and $485.6 million, respectively. 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.

(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 2015 and 2014, there were no required employee contributions. For the years ended December 31, 2015 and 2014, plan expense allocated to Health Plan, primarily employer contributions, was $9.8 million and $9.3 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, 2015 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 2015 and 2014 is for the plan's year-end in 2014 and 2013, 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 2015 and 2014 employer expense. Minimum contributions, based on contract rates, are required to be made monthly.

Pension Fund	EIN-PN	Pension Protection Act Zone Status		FIP/RP Status Pending / Implemented	(In thousands) Health Plan's Contributions December 31,		Surcharge Imposed	Health Plan's Contributions to Plan Exceeded More Than 5% of Total Contributions (1)		Expiration Date of Collective Bargaining Agreement
		2015	2014		2015	2014		2014	2013	
Central Pension Fund of the IUOE and Participating Employers	364052392-001	Green	Green	N/A	$ 133	$ 227	No	No	No	3/3/2016

(1) At the date the financial statements were issued, the most recent Form 5500 available was for the plan year ended January 31, 2015.

(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.

The postretirement benefit trust 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 retirement benefit expense and related prepaid or accrued benefit costs to Health Plan based on participant demographics and plan provisions.

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 resulted in an increase in liabilities of $4.2 million.

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

	2015	2014
Change in benefit obligation:		
Benefit obligation at beginning of year	$ 72,352	$ 53,710
Service cost	4,230	2,361
Interest cost	3,172	2,537
Plan amendments	15,523	—
Plan clarifications	—	(1,213)
Benefits paid or provided	(2,102)	(1,442)
Net actuarial loss (gain)	(4,756)	16,399
Benefit obligation at end of year	88,419	72,352
Change in plan assets:		
Fair value of plan assets at beginning of year	2,380	—
Actual return on plan assets	(309)	—
Contributions	21,963	3,822
Benefits paid or provided	(2,102)	(1,442)
Fair value of plan assets at end of year	$ 21,932	$ 2,380
Funded status	$ (66,487)	$ (69,972)

	2015	2014
Liabilities recognized consist of:		
Accrued benefit cost	$ (19,162)	$ (30,430)
Postretirement benefit liability	(41,098)	(21,411)
Total postretirement benefit liabilities recognized	$ (60,260)	$ (51,841)
Amounts recognized in unassigned surplus that have not been recognized as components of benefits expense:		
Net actuarial loss	$ 12,799	$ 18,036
Prior service cost	34,526	21,506
Amounts recognized in unassigned surplus	47,325	39,542
Unrecognized transition liability	(6,227)	(18,131)
Net amounts recognized in unassigned surplus	$ 41,098	$ 21,411

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):

	2015	2014
Service cost	$ 4,230	$ 2,361
Interest cost	3,172	2,537
Expected return on plan assets	(167)	—
Amortization of prior service cost	2,503	2,302
Amortization of net actuarial loss	957	—
Postretirement benefits expense	10,695	7,200
Other changes in plan assets and benefit obligations recognized in unassigned surplus:		
Transition liability recognized	11,904	4,411
Prior service cost	15,523	—
Amortization of prior service cost	(2,503)	(2,302)
Plan clarifications	—	(1,213)
Net actuarial loss (gain)	(4,280)	16,399
Amortization of net actuarial loss	(957)	—
Total recognized in surplus	19,687	17,295
Total recognized in net periodic benefit cost and surplus	$ 30,382	$ 24,495

During 2016, $3.6 million and $259 thousand of prior service cost and net actuarial loss, respectively, will be amortized from unassigned surplus into postretirement benefits expense.

During 2015, the employer contributions and benefits paid or provided were $22.0 million and $2.1 million, respectively. 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 2015 and 2014, there were no participant contributions from active employees.

At December 31, 2015, the unrecognized transition liability was as follows (in thousands):

Amount recognized for 2015 is the greater of:		
10% of initial surplus impact	$	3,198
Net amortization components of net periodic benefit cost	$	3,460
Unrecognized transition liability at December 31, 2014	$	(18,131)
Transition liability recognized		3,460
Additional transition liability recognized due to net actuarial gains		8,444
Total transition liability recognized during 2015		11,904
Unrecognized transition liability at December 31, 2015	$	(6,227)

Of the $6.2 million unrecognized transition liability at December 31, 2015, 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 2017. 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:

	2015	2014
Weighted average discount rate used for calculating non-union plan postretirement benefits expense from January 1 to December 31	4.35%	5.25%
Weighted average discount rate for calculating union plan postretirement benefits expense from January 1 to January 24	4.35%	5.25%
Weighted average discount rate for calculating union plan postretirement benefits expense from January 25 to December 31	3.90%	5.25%
Weighted average discount rate for calculating December 31 accumulated postretirement benefit obligation	4.75%	4.35%
Expected long-term rate of return on plan assets for calculating benefits expense	7.00%	N/A

The following were the assumed health care cost trend rates used to determine postretirement benefits expense for the year 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 - 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	2014	2020	2026 / 2022

The following were the assumed health care cost trend rates used to determine the December 31, 2014 and 2015 benefit obligation and postretirement benefits expense for the year ended December 31, 2015:

	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%
Initial trend rate - 2015	5.50% / 5.25%	8.00% / 8.00%	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 $7.4 million and the service cost plus interest by $663 thousand. A decrease of 1% in the health care medical trend rate would decrease the benefit obligation by $6.4 million and the service cost plus interest by $562 thousand.

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

2016	$ 2,039
2017	2,247
2018	2,476
2019	2,812
2020	3,283
2021 - 2025	24,373

Explanation of Investment Strategies and Policies

A total return investment approach is employed for the retirement benefit trust whereby the assets are invested in various 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 retirement benefit trust 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, 2015, the estimated fair value of total retirement benefit trust assets 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	$ —	$ 650	$ —	$ 650
Alternative investments:				
Risk parity	—	375	340	715
Total assets	—	1,025	340	1,365

For the year ended December 31, 2015, the reconciliation of assets with fair value measurements using significant unobservable inputs (level 3) was as follows (in millions):

	Alternative investments
Beginning balance	$ —
Transfers into level 3	—
Changes related to actual return on plan assets	(10)
Purchases, sales, and settlements - net	350
Ending balance	$ 340
Total year-to-date net gains related to assets held at December 31, 2015	$ (10)

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

	2015 target range	2015 ELTRA
Alternative investments	100%	7.00%
Total	100%	7.00%

Risk parity investments include redemption restrictions. 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. Risk parity investments of $100 million are subject to lock-up periods of up to 9 months.

(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, 2015 and 2014, 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, options to purchase at appraised value, and renewal options for additional periods. During 2015 Health Plan gave notice to exercise its option to purchase the building and land of a facility it is currently leasing. Closing of the purchase is expected to occur on June 1, 2017 or later. The purchase price has not been determined.

At December 31, 2015, minimum commitments under noncancelable leases extending beyond one year were as follows (in thousands):

2016	$ 23,473
2017	22,662
2018	18,808
2019	16,158
2020	16,122
Thereafter	49,758
Total	$ 146,981

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

	2015	2014
Minimum rentals	$ 29,445	$ 29,153
Imputed rent for owned and occupied medical and administrative building	51,458	49,849
Total	$ 80,903	$ 79,002

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, 2015, minimum purchase commitments extending beyond one year were as follows (in thousands):

2016	$ 414
2017	—
2018	22
2019	—
2020	—
Thereafter	—
	$ 436

During 2015 and 2014, Health Plan's total purchases under contracts with minimum purchase commitments were $61 thousand and $11 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 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. At December 31, 2015 and 2014, the regulatory capital and surplus of Health Plan exceeded the authorized control level by approximately $151.8 million and $93.5 million, respectively.

In accordance with Maryland code, Health Plan must receive prior written approval from the MIA to pay a dividend or distribution during 2016 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, 2015, or (b) Health Plan's net gain from operations on a statutory basis for the year ended December 31, 2015. Accordingly, during 2016, prior approval from the MIA is required for any dividend or distribution payment which exceeds $20.9 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 2015	2014
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	31,000
December 30, 2014	December 29, 2021	5.00%	100,000	100,000
March 31, 2015	March 31, 2022	5.00%	50,000	—
December 30, 2015	December 30, 2022	5.00%	40,000	—
	Total		$ 354,000	$ 264,000

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, 2015 and 2014, unapproved interest payable totaled $23.6 million and $15.0 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 $40.0 million received in conjunction with the subordinated note issued on December 30, 2015 was held as cash in a single financial institution at December 31, 2015. 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 2015 and 2014 was 2.85% and 2.90%, respectively.

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

For the years ended December 31, risk-sharing provisions relating to the PPACA and MTRP were as follows (in thousands):

		2015		2014
a.	ACA Permanent Risk Adjustment Program			
i.	Premium adjustments receivable due to ACA Risk Adjustment	$ 24	$	—
ii.	Risk adjustment user fees payable for ACA Risk Adjustment	95		32
iii.	Premium adjustments payable due to ACA Risk Adjustment	40,000		—
iv.	Reported as revenue in premium for accident and health contracts (written/collected) due to ACA Risk Adjustment	(55,630)		—
v.	Reported in expenses as ACA Risk Adjustment user fees (incurred/paid)	96		32
b.	ACA Transitional Reinsurance Program			
i.	Amounts recoverable for claims paid due to ACA Reinsurance and MTRP	$ 11,843	$	3,165
ii.	Amounts recoverable for claims unpaid due to ACA Reinsurance and MTRP (contra-liability)	2,369		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	20,763		27,010
v.	Ceded reinsurance premiums payable due to ACA Reinsurance	2,540		1,162
vi.	Liability for amounts held under uninsured plans contributions for ACA Reinsurance	—		—
vii.	Ceded reinsurance premiums due to ACA Reinsurance	2,540		1,162
viii.	Reinsurance recoveries (income statement) due to ACA Reinsurance and MTRP payments or expected payments	16,763		5,461
ix.	ACA Reinsurance Contributions - not reported as ceded premium	20,763		27,010
c.	ACA Temporary Risk Corridors Program			
i.	Accrued retrospective premium due from ACA Risk Corridors	$ 36	$	—
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)	253		—
iv.	Effect of ACA Risk Corridors on change in reserves for rate credits	—		—

The following is a roll-forward of prior year PPACA risk sharing provisions as of December 31, 2015 (in thousands):

	Accrued During the Prior Year on Business Written Before December 31 of the Prior Year		Received or Paid as of the Current Year on Business Written Before December 31 of the Prior Year		Differences		Adjustments			Unsettled Balances as of the Reporting Date	
					Prior Year Accrued Less Payments	Prior Year Accrued Less Payments	To Prior Year Balances	To Prior Year Balances		Cumulative Balance from Prior Years	Cumulative Balance from Prior Years
	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Ref	Receivable	(Payable)
Permanent PPACA Risk Adjustment Program											
Premium adjustments receivable	—	—	854	—	(854)	—	878	—	A	24	—
Premium adjustments (payable)	—	—	—	(16,508)	—	(16,508)	—	(16,508)	A	—	—
Subtotal PPACA Permanent Risk Adjustment Program	—	—	854	(16,508)	(854)	(16,508)	878	(16,508)		24	—
Transitional PPACA Reinsurance Program and MLR											
Amounts recoverable for claims paid	3,165	—	8,013	—	(4,848)	—	4,848	—	B	—	—
Amounts recoverable for claims unpaid (reserve liability)	2,296	—	—	—	2,296	—	(2,296)	—	B	—	—
Amounts recoverable relating to retrospective plans	—	—	—	—	—	—	—	—		—	—
Liability for contributions payable due to PPACA Reinsurance - not reported as ceded premium	—	27,010	—	27,010	—	—	—	—		—	—
Ceded reinsurance premiums payable	—	1,162	—	1,162	—	—	—	—		—	—
Liability for amounts held under retrospective plans	—	—	—	—	—	—	—	—		—	—
Subtotal PPACA Transitional Reinsurance Program and MLR	5,461	28,172	8,013	28,172	(2,552)	—	2,552	—		—	—
Temporary PPACA Risk Corridors Program											
Accrued retrospective premium	—	—	217	—	(217)	—	253	—	C	36	—
Reserve for rate credits or policy experience rating refunds	—	—	—	—	—	—	—	—		—	—
Subtotal PPACA Risk Corridors Program	—	—	217	—	(217)	—	253	—		36	—
Total for PPACA Risk Sharing Provisions	5,461	28,172	9,084	44,680	(3,623)	(16,508)	3,683	(16,508)		60	—

Explanation of Adjustments:

A. Net Risk Adjustment Payables and Receivables were recorded for the first time in Q2 2015. Gross Receivables and Payables segregated in Q3 due to varying payment schedules.

B. Reinsurance recoveries were paid out at 100% co-insurance rate rather than 80% as previously estimated.

C. Risk Corridor Receivables were recorded for the first time in Q3 2015.

(15) Liquidity

At December 31, 2015, due in part to the subordinated notes issued, Health Plan has positive statutory capital and surplus totaling $209.2 million. The statutory capital and surplus represents 365% of risk-based capital. However, at December 31, 2015, Health Plan's GAAP net deficit is $130.7 million, a decrease of $10.7 million from December 31, 2014. The decrease in GAAP net deficit is primarily due to the net loss of $7.7 million in 2015 offset by a $19.0 million decrease 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.

Schedule I

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

Statutory Supplemental Schedule of Investment Information - Summary Investment Schedule

December 31, 2015

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
Bonds:				
U.S. Treasury securities	$ 107,488,568	12.29%	$ 107,488,568	12.29%
U.S. government agency obligations (excluding mortgage-backed securities):				
Issued by U.S. government agencies	—	—	—	—
Issued by U.S. government-sponsored agencies	—	—	—	—
Foreign government (including Canada, excluding mortgage-backed securities)	253,804	0.03%	253,804	0.03%
Securities issued by states, territories, and possessions and their political subdivisions in the U.S.:				
States, territories, and possessions – general obligations	145,775	0.02%	145,775	0.02%
Political subdivisions of states, territories, and possessions - general obligations	—	—	—	—
Revenue and assessment obligations	716,502	0.08%	716,502	0.08%
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	600,437	0.07%	600,437	0.07%
All other	—	—	—	—
CMOs and REMICs:				
Issued or guaranteed by GNMA, FNMA, FHLMC, or VA	9,538,680	1.09%	9,538,680	1.09%
Issued by non-U.S. government issuers and collateralized by MBS, issued or guaranteed by GNMA, FNMA, FHLMC, or VA	—	—	—	—
All other	8,510,797	0.97%	8,510,797	0.97%
Other debt and other fixed income securities (excluding short term):				
Unaffiliated domestic securities (includes credit tenant loans and hybrid securities)	86,825,637	9.92%	86,825,637	9.92%
Unaffiliated foreign securities (including Canada)	30,004,255	3.43%	30,004,255	3.43%
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, 2015

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	583,638,397	66.71%	583,638,397	66.71%
Property held for production of income	3,899,180	0.45%	3,899,180	0.45%
Property held for sale	—	—	—	—
Collateral loans	—	—	—	—
Policy loans	—	—	—	—
Receivables for securities	—	—	—	—
Cash (overdraft) and short-term investments - net	43,245,945	4.94%	43,245,945	4.94%
Other invested assets	—	—	—	—
Total invested assets	$ 874,867,977	100.00%	$ 874,867,977	100.00%

* Gross investment holdings as valued in compliance with *NAIC Accounting Practices and Procedures Manual*.

See accompanying independent auditors' report.

Schedule II

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

Statutory Supplemental Schedule of Investment Information - Investment Risks Interrogatories

December 31, 2015

1. Health Plan's total admitted assets as reported on page two of its *Annual Statement* are $ 1,148,312,174

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. Money Market Fund	SSGA	$ 6,400,854	0.56%
b. Bond	JP Morgan Chase & Co	5,848,359	0.51%
c. Bond	Fannie Mae	4,168,071	0.36%
d. Bond	Citigroup Inc	3,957,470	0.34%
e. Bond	Santander	3,846,606	0.33%
f. Bond	Hyundai	2,783,167	0.24%
g. Bond	General Motors	2,730,952	0.24%
h. Bond	Morgan Stanley	2,626,958	0.23%
i. Bond	Ford	2,557,297	0.22%
j. Bond	General Electric	2,503,807	0.22%

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	$ 212,908,202	18.54%	P/PSF-1	$ —	—
NAIC - 2	38,868,755	3.38%	P/PSF-2	—	—
NAIC - 3	—	—	P/PSF-3	—	—
NAIC - 4	—	—	P/PSF-4	—	—
NAIC - 5	—	—	P/PSF-5	—	—
NAIC - 6	—	—	P/PSF-6	—	—
	$ 251,776,957			$ —	

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, 2015	$ 26,870,417	2.34%
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, 2015

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 [ ]

Schedule H

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

Statutory Supplemental Schedule of Investment Information - Investment Risks Interrogatories

December 31, 2015

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 Health plan does not have aggregate mortgage loans

18 Assets held in each of the five largest investments in one parcel or group of contiguous parcels of 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		—	—

19 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 [ ]

20 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	3rd 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	—	—	—	—	—

21 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	—	—	—	—

Schedule II

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

Statutory Supplemental Schedule of Investment
Information - Investment Risks Interrogatories

December 31, 2015

22. 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	—	—	—	—	—

23. 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 9.

KPMAS Strategic Plan Forecast 2016

Mid-Atlantic States

Strategic Plan

($000s, except for membership and PMPMs)	2016	2017	2018	2019	2020	2021	2022	2023	2024
MEMBERSHIP									
Year-end Membership	634,175	675,725	722,923	775,528	837,175	903,330	973,475	1,049,624	1,120,277
Growth	8.1%	6.6%	7.0%	7.3%	7.9%	7.9%	7.8%	7.8%	6.7%
Average Membership	623,226	667,151	697,069	746,891	803,935	867,752	935,814	1,008,871	1,082,178
Change in Membership (%)	7.6%	7.0%	4.5%	7.1%	7.6%	7.9%	7.8%	7.8%	7.3%
Member Months	7,478,710	8,005,810	8,364,823	8,962,694	9,647,225	10,413,023	11,229,772	12,106,449	12,986,136
REVENUE	**$3,323,169**	**$3,607,712**	**$3,851,479**	**$4,218,817**	**$4,647,770**	**$5,142,493**	**$5,692,386**	**$6,305,709**	**$6,954,190**
Overall Revenue Growth	9.6%	8.6%	6.8%	9.5%	10.2%	10.6%	10.7%	10.8%	10.3%
Revenue PMPM	444.35	450.64	460.44	470.71	481.77	493.85	506.90	520.86	535.51
Increase PMPM	1.9%	1.4%	2.2%	2.2%	2.4%	2.5%	2.6%	2.8%	2.8%
EXPENSES	**$3,256,706**	**$3,524,735**	**$3,747,488**	**$4,092,252**	**$4,499,041**	**$4,962,506**	**$5,493,153**	**$6,085,009**	**$6,710,793**
Overall Expense Growth	8.9%	8.2%	6.3%	9.2%	9.9%	10.3%	10.7%	10.8%	10.3%
Expense PMPM	435.46	440.27	448.01	456.59	466.36	476.57	489.16	502.63	516.77
Increase PMPM	1.3%	1.1%	1.8%	1.9%	2.1%	2.2%	2.6%	2.8%	2.8%
OPERATING INCOME	**$ 66,463**	**$ 82,977**	**$ 103,990**	**$ 126,564**	**$ 148,729**	**$ 179,987**	**$ 199,234**	**$ 220,700**	**$ 243,397**
Margin	2.0%	2.3%	2.7%	3.0%	3.2%	3.5%	3.5%	3.5%	3.5%

EXHIBIT 10
Attestation

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 1/4/2017 Date

Name: Peter Mbugua, Senior Consultant, Delivery System Planning

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.

Andrew J Solberg 12/29/16

Signature Date

Name: Andrew Solberg, CON Consultant

EXHIBIT 11
CON Application Tables C, E and L

TABLE C. CONSTRUCTION CHARACTERISTICS

INSTRUCTION: If project includes non-hospital space structures (e.g., parking garages, 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 **Total Square Footage**	List Number of Feet, if applicable Total Square Feet
First Floor	
Second Floor	
Third Floor	
Fourth Floor	
Fifth Floor	
Six Floor	520
Average Square Feet	**520**
Perimeter in Linear Feet	Linear Feet
First Floor	
Second Floor	
Third Floor	
Fourth Floor	
Fifth Floor	
Six Floor	100
Average Linear Feet	**100**
Wall Height (floor to eaves)	Feet
First Floor	
Second Floor	
Third Floor	
Fourth Floor	
Fifth Floor	
Six Floor	14'
OTHER COMPONENTS	
Elevators	List Number
Passenger	3
Freight	1
Sprinklers	Square Feet Covered
Wet System	520
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	$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		$600,000	$600,000	
(2) Fixed Equipment (not included in construction)			$0	
(3) Architect/Engineering Fees		$120,000	$120,000	
(4) Permits (Building, Utilities, Etc.)		$49,556	$49,556	
SUBTOTAL	$0	$769,556	$769,556	*Ensure that SUBTOTAL includes all categories under 1.c.*
d. Other Capital Costs				
(1) Movable Equipment / Furnishings		$617,349	$617,349	
(2) Contingency Allowance		$163,501	$163,501	
(3) Gross Interest during construction period			$0	
(4) PM recharge		$199,835	$199,835	
(5) IT		$52,171	$52,171	
(6) Terminal Cleaning		$138,000	$138,000	
SUBTOTAL		$1,170,856	$1,170,856	*Calculate sum of all categories under 1.d.*
TOTAL CURRENT CAPITAL COSTS	$0	$1,940,412	$1,940,412	*Ensure that TOTAL CURRENT CAPITAL COSTS includes all SUBTOTALS above*
e. Inflation Allowance			$57,940	*Inflation should only be included in this category*
TOTAL CAPITAL COSTS	$0	$1,940,412	$1,998,352	*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			$0	
e. Liquidation of Existing Debt			$0	
f. Debt Service Reserve Fund			$0	
g. Other *(Specify/add rows if needed)*			$0	
SUBTOTAL			$0	*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	$1,940,412	$1,998,352	*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			$0	
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			$0	*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. WORK FORCE 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, Perioperative Services	0.25		$56,756			$0			$0	0.3	$56,756	
Coordinator, Perioperative Services	0.25		$23,878			$0			$0	0.3	$23,878	
Manager, Perioperative Scheduling & PEEC	0.25		$36,631			$0			$0	0.3	$36,631	
Manager, Perioperative Facilities & Materials	0.5		$50,100			$0			$0	0.5	$50,100	
Manager, Sterile Processing	1.00		$117,332			$0			$0	1.0	$117,332	
Director, Assistant Perioperative Services	0.5		$89,648			$0			$0	0.5	$89,648	
Manager, Clinical Operations	1.00		$157,866			$0			$0	1.0	$157,866	
						$0			$0	0.0	$0	
Total Administration	3.75		$532,211			$0			$0	3.8	$532,211	Calculate the sum of Administration
Direct Care Staff (List general categories, add rows if needed)												
Lead RN	3.75	$110,448	$414,180	0.08	$110,448	$8,836			$0	3.8	$423,016	
OR RN	5.00	$101,192	$505,960	0.95	$101,192	$96,132			$0	6.0	$602,092	
PACU RN	7.40	$103,958	$769,289	3.64	$103,958	$378,407			$0	11.0	$1,147,696	
CA	1.00	$49,941	$49,941	0.12	$49,941	$5,993			$0	1.1	$55,934	
Orderly	1.00	$41,183	$41,183	4.96	$41,183	$204,168			$0	6.0	$245,331	
Surgical Tech	3.00	$65,645	$196,935	0.65	$65,645	$42,669			$0	3.7	$239,604	
RNFA/PA	2.00	$101,192	$202,384	1.07	$101,192	$108,275			$0	3.1	$310,659	
Anesthesia tech	2.00	$50,960	$101,920	1.07	$50,960	$54,527			$0	3.1	$156,447	
Total Direct Care	25.15		$2,281,772	12.54		$899,009			$0	37.7	$3,180,781	Calculate the sum of Direct Care
Support Staff (List general categories, add rows if needed)												
Receptionist	2.00	$46,842	$93,684	0.68	$46,842	$31,853						
Lead CSP tech	1.00	$58,552	$58,552	0.03	$58,552	$1,757						
Cnetral Sterile	3.00	$53,414	$160,242	1.61	$53,414	$85,997						
Surgery Scheduler			$0	1.21	$56,867	$68,809						
PEEC			$0	1.12	$124,010	$138,891			$0	1.1	$138,891	
Total Support	6.00		$312,478	4.65		$327,306			$0	10.7	$638,784	Calculate the sum of Administration Support Staff
REGULAR EMPLOYEES TOTAL	34.90		$3,128,461	17.2		$1,226,315			$0	52.1	$4,352,776	Calculate the sum of Administration, Direct Care, and Support Staff
2. Contractual Employees												
Administration (List general categories, add rows if needed)												
			$0			$0			$0	0.0	$0	
			$0			$0			$0	0.0	$0	
			$0			$0			$0	0.0	$0	
			$0			$0			$0	0.0	$0	
Total Administration			$0			$0			$0	0.0	$0	Calculate the sum of Administration
Direct Care Staff (List general categories, add rows if needed)												
			$0			$0			$0	0.0	$0	
			$0			$0			$0	0.0	$0	
			$0			$0			$0	0.0	$0	
			$0			$0			$0	0.0	$0	
Total Direct Care Staff			$0			$0			$0	0.0	$0	Calculate the sum of Direct Care
Support Staff (List general categories, add rows if needed)												
			$0			$0			$0	0.0	$0	
			$0			$0			$0	0.0	$0	
			$0			$0			$0	0.0	$0	
			$0			$0			$0	0.0	$0	
Total Support Staff			$0			$0			$0	0.0	$0	Calculate the sum of Administration Support Staff
CONTRACTUAL EMPLOYEES TOTAL			$0			$0			$0	0.0	$0	Calculate the sum of Administration, Direct Care, and Support Staff
Benefits (State method of calculating benefits below):												
												Include the method of calculating benefits in green field at far left
TOTAL COST	34.9		$3,128,461	17.2		$1,226,315	0.0		$0		$4,352,776	Ensure that the sums and Total Cost of Regular Employees Total and Contractual Employee are correct

* The projected FTEs and cost for the entire facility should equal the current number of FTEs and cost plus changes in FTEs and cost related to the proposed project plus other expected changes in staffing.