Banner Health®

1441 North 12th Street, Phoenix, AZ 85006
602-495-4000
BannerHealth.com

July 15, 2005

Hon. Charles E. Grassley
Chairman
U.S. Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, D.C. 20510-6200

Re: Responses to Letter of May 25, 2005

Dear Senator Grassley:

Please find attached Banner Health's responses to your letter of May 25, 2005, sent to Banner Health and nine other hospital systems around the country. We appreciate the importance of the policy issues addressed in the Committee's letter, and we have attempted in good faith to provide information responsive to the Committee's inquiries within the timeframe imposed.

We have answered the questions keeping in mind that, like most of the other nine hospital systems that received the May 25 letter, Banner is a defendant in pending putative class action litigation alleging that Banner has violated various laws in its billing and collection practices involving uninsured patients. We have noted the high degree of overlap between the questions posed by the Committee's letter and the discovery requests submitted by the plaintiffs' trial lawyers in many of these cases, and we are aware of media reports of cooperation between Richard Scruggs, who is of counsel to the plaintiffs in the lawsuit pending against Banner Health, and the Committee's staff. Although many of these lawsuits have been dismissed for failure to state viable legal claims, some of the damages theories pled by the plaintiffs in the pending lawsuit against Banner would, if found viable, have a substantial adverse effect on Banner and its ability to continue to serve its communities. Accordingly, our responses are framed to respond to the inquiry without prejudicing Banner's defenses in the pending litigation brought by Mr. Scruggs and his colleagues.

In order to understand the responses, it may be helpful to have some background information on Banner. Banner was initially formed in 1938 as a North Dakota nonprofit corporation known as Lutheran Hospitals and Homes Society headquartered in Fargo, North Dakota. Over the ensuing years, LHHS (later known as Lutheran Health Systems) owned, leased or managed hospitals and long-term care facilities in several midwestern and western states. On September 1, 1999, Lutheran Health Systems acquired substantially all of the assets, and assumed substantially all of the liabilities, of Samaritan

Health System, an Arizona nonprofit corporation with hospitals primarily in the Phoenix metropolitan area. Shortly thereafter, Lutheran Health Systems changed its name to Banner Health System (later shortened to "Banner Health"). Following the relocation of its corporate headquarters to Phoenix, Arizona in 2001, Banner transferred its state of domicile from North Dakota to Arizona.

Following the 1999 acquisition, Banner focused upon integrating its financial, clinical and operational systems into a cohesive and efficient hospital company, Because of the dual legacy of Banner, however, it is difficult in many instances to retrieve data prior to this operational integration, including some of the data requested in the Committee's letter. Today, Banner owns, leases or operates 19 acute care hospitals in seven states with a total of approximately 2,970 licensed beds; one freestanding behavioral health facility with approximately 100 licensed behavioral beds, and five facilities with approximately 328 licensed long-term care beds (including long-term care beds within acute care hospitals). Banner also operates home health agencies, nursing registries, physician clinics and home medical equipment supply services, although the vast majority of Banner's activity derives from its hospital operations. Approximately 75% of Banner's revenue derives from its operations in the greater Phoenix metropolitan area. Banner employs approximately 25,000 people, of whom approximately 17,000 are in the State of Arizona.

We hope that you and the Committee's staff will find the enclosed information (and the accompanying documents) helpful in assessing issues related to the uninsured. As a nonprofit hospital system, Banner is committed to providing high-quality healthcare to the uninsured and hopes that the Committee will pursue these issues in a way that will promote the provision of healthcare to the uninsured while also recognizing that Banner must also strive to provide a myriad of other benefits to the communities we serve, some of which are among the fastest growing regions in the country. While serving the uninsured obviously is one important benefit to any community – particularly in a state such as Arizona – there are many other unmet needs in the communities we serve, and a seemingly infinite number of demands on our finite resources.

Thank you for your consideration of these matters.

Sincerely,

David M. Bixby
Senior Vice President/General Counsel

cc: (w/Responses but not Attachments) Hon. Jon Kyl

RESPONSES TO MAY 25, 2005 COMMITTEE LETTER

A. CHARITY CARE AND COMMUNITY BENEFIT

1. How does your organization define charity care? What types of activities or programs does your organization include in its definition of charity care? Which of these activities or programs would your organization not incur, at all or to the same extent, if you were organized and operated as a for-profit hospital? Does your organization maintain a charity policy? If so, please describe the policy or provide a copy of such policy. Does this policy require that certain types and amount of charity care be provided?

Response: For financial reporting purposes, Banner defines charity care to be medical care provided without charge or at reduced charge to uninsured and underinsured individuals who are determined to be unable to pay because of socioeconomic factors. In order for such charges to be classified as charity care, the individuals receiving or responsible for the cost thereof must make application for financial assistance to Banner.[1] Unreimbursed medical care provided to uninsured or underinsured individuals who do not make application for financial assistance (except, for certain Banner facilities, persons who file for personal bankruptcy) is reported as bad debt, and not as charity care. Because Banner does not pursue collection of amounts reported as charity care, amounts classified as charity care are not included in Banner's revenue in its external financial statements. As noted below in our responses, Banner engages in a number of other activities that benefit the communities that we serve, including making health care services available in various ways to medically indigent persons but are classified by us as "community benefit" rather than "charity care" in keeping with the foregoing definition.

Banner maintains a policy for financial assistance for uninsured individuals, and a separate policy for financial assistance for underinsured individuals. Copies of both policies are being provided. The current policy for financial assistance for uninsured individuals sets forth two programs. Under the Basic Financial Assistance Program, uninsured persons who simply avow to having an annual household income of $125,000 or less are eligible to pay rates comparable to the prevailing commercial insurer rates received by Banner for medical care. In Arizona, those rates equal 150% of expected Medicare DRG reimbursement for inpatient services, and 28% of Banner's usual and customary charges (also referred to as "full billed charges" or "chargemaster charges") (as filed annually with the Arizona Department of Health Services) for outpatient services. In the other states in which Banner operates, those rates equal 225% of expected

[1] In Colorado, persons who cannot qualify for Medicaid are required to qualify for the Colorado Indigent Care Program. This program provides for annual partial lump sum reimbursement to participating Colorado hospitals for care provided to persons who qualify for the CICP program. The charges for care provided to CICP patients, net of the lump sum reimbursement, is included in the charity care reported by Banner.

Medicare DRG reimbursement for inpatient services, and 75% of full billed charges (as set forth in the facility chargemaster) for outpatient services.

Under the Enhanced Financial Assistance Program, uninsured persons having household income up to 500% of the Federal Poverty Level are eligible for free or substantially discounted services on a sliding scale based on family income. In order to qualify for the Enhanced Financial Assistance Program, individuals must complete a full charity care application and must also apply for, and be denied, Medicaid assistance. Persons who qualify for the Enhanced Financial Assistance Program and have household incomes of 150% or less of the Federal Poverty Level will receive free medical care at all Banner facilities. Persons earning over 150% and up to 500% of the Federal Poverty Level are eligible for discounted care ranging, depending upon income, from 25% to 125% of expected Medicare DRG reimbursement for inpatient services, and from 6% to 24% of full billed charges in Arizona. In the other states in which Banner operates, the discounts for persons earning over 150% and up to 500% of the Federal Poverty Level range from 25% to 160% of expected Medicare DRG reimbursement for inpatient services, and from 15% to 55% of full billed charges for outpatient services.

Banner also has a policy for financial assistance to insured individuals, in order to assist such persons to cope with increasingly burdensome self-pay deductibles and co-payments. Persons must complete a full charity care application in order to be eligible for this program. This policy applies where the contract with the insurance company does not dictate a specific discount to be applied to the insurer's enrollees. The policy grants insured individuals having household incomes up to 200% of the Federal Poverty Level a sliding scale discount from full billed charges depending upon the size of the self-pay portion of the account and the individual's income. Under the policy, insured persons having household incomes of 100% of the Federal Poverty Level or less are not required pay the self-pay portion of their account. For persons earning up to 200% of the Federal Poverty Level, the discount ranges from 70% (i.e., the individual pays 30% of full billed charges) for accounts under $1,000, to 100% (i.e., the individual pays nothing) for accounts over $5,000.

In addition to these financial assistance programs, Banner offers a prompt payment discount of 20% to uninsured patients who pay accounts in full in advance (based on estimated charges), and within 10 days of the final itemized statement. Banner also offers an installment payment program for self-pay patients unable to pay the amount owed in full at time of service. This program provides for payment programs of up to 24 months, depending upon the size of the account balance.

In addition to medical care that is reported for financial purposes as "charity care" in accordance with the definition provided above, Banner engages in substantial activities that are reported as community benefit rather than as charity care. These activities are in furtherance of Banner's tax-exempt status as an organization described in Section 501(c)(3) of the Internal Revenue Code. These activities cover a wide spectrum, and generally serve to promote the health of the communities served by Banner, and many of these programs are targeted towards making healthcare available and accessible to the uninsured and indigent in Banner's communities. As the Committee must be aware, the

promotion of health is, and has long been, recognized by the Internal Revenue Service as a legitimate charitable purpose and a valid basis for tax-exempt status under Section 501(c)(3). See, e.g., Rev. Rul. 69-545; Rev. Rul 83-157.[2] See also Response B.19 below.

The community benefit activities include, among others, the following activities that make healthcare more accessible and affordable for uninsured or underinsured persons:

- Subsidization of losses incurred through participation in Medicaid and the Arizona Health Care Cost Containment System.
- Subsidization of a Level 1 Trauma Center serving the entire State of Arizona.
- Subsidization of an emergency department physician on-call reimbursement program to ensure that all patients, including uninsured patients, will have access to physician specialists in Banner emergency rooms.
- Participation in HealthCare Connect Network, a nonprofit health plan partially funded by a federal grant that negotiates discounts for uninsured and underinsured persons enrolled in the plan.
- Subsidization of pre-natal and post-natal care for patients qualified under the Arizona Emergency Services Program.
- Subsidization of staffing and management of Phoenix Poison Control Center.
- Funding and staffing of several school-based clinics in elementary schools in lower-income areas of the Phoenix metropolitan area.
- Multiple community event sponsorships relating to the promotion of health and community well-being.
- Multiple community health education and wellness fairs, programs and events.
- Subsidization of pastoral care services.
- Subsidization of immunization and mammography community clinics.
- Subsidization of 24-hour patient crisis and health referral call line.
- Banner-supported professional staff involvement with nonprofit organizations to provide support groups for cancer, liver disease, and kidney disease patients.
- Rural outreach to underserved areas, including rural liver disease program and supply of much-needed physician specialty care.
- Coordination and active leadership and participation by Banner personnel with area community hazardous material and emergency personnel for response to bio-hazard, bio-terror and mass casualty disasters.
- Partnering with public and local governmental entities, such as City of Phoenix and Arizona State University, to provide professional staffing and support to clinic programs.
- Multiple smaller programs for specific lower-income populations coming in contact with Banner facilities, such as child-seat giveaway and education, and reconditioning and delivery of home nebulizer machines.

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[2] It should be noted that in December 2004, Banner Health completed a lengthy comprehensive audit by the Internal Revenue Service covering the tax years 2000 and 2001. This audit, which examined a wide variety of Banner's activities and practices, including its joint venture activities, was concluded with no issues being raised as to the validity of Banner's status as an exempt organization under Section 501(c)(3).

- Prescription assistance programs at McKee Medical Center and North Colorado Medical Center provide assistance to low income individuals who have chronic medication needs, using United Way, local foundation and Banner funding, and assist eligible patients to qualify for, and obtain prescriptions donated by pharmaceutical companies.

Banner is also engaged in a wide variety of medical education, research, community outreach and community education activities. Partial detailed lists of these community benefit activities are set forth in Responses Nos. A.15 and A.20 below.

In addition to activity reported as charity care and community benefit, Banner also benefits the communities it serves by heavily investing in new or expanded facilities and new healthcare technologies to keep up with the accelerating demand for healthcare services in Banner's primary markets in Maricopa County, Arizona, and the northern Front Range region of Colorado. Banner has also made a substantial commitment to a major escalation in the overall quality of care provided at Banner facilities through substantial investment in clinical care infrastructure, including electronic medical records, computerized physician order entry systems, clinical protocols and standardization, and other expensive information technology to provide data and business analytics to constantly improve and upgrade clinical processes and quality, and through a major investment in the training of a workforce and medical staff that can effectively use these tools to provide excellent patient care in Banner's hospitals. Between 2005 and 2011, Banner anticipates making capital investments of over $2.8 billion to serve its communities.

Because Banner has been organized and operated exclusively as a tax-exempt nonprofit organization described in Section 501(c)(3) since its incorporation in 1938 as Lutheran Hospitals and Homes Society, Banner has never undertaken an analysis as to which of its activities, policies, programs and community benefit activities it would discontinue if it were a for-profit organization. Accordingly, Banner cannot answer the Committee's inquiry as to the amount of charity care or community benefit activities that it would engage in if it were a for-profit hospital corporation.

2. What are the 10 largest categories of charity care expenditures incurred by your hospital for the past five years? How does this differ from 10 years ago? 25 years ago?

Response: This question is ambiguous in that it is not clear what is meant by "categories of charity care expenditures". As noted in Response No.1, Banner only includes in the definition of "charity care" the charges for medical care provided without cost or at reduced cost to uninsured and underinsured individuals, and for medical care provided to patients expressing a willingness to pay but who are determined to be unable to pay because of socioeconomic factors. Within the definition, it is not possible to retrieve data corresponding to the types of financial accommodations accorded to uninsured versus underinsured individuals.

The following table sets forth the charity care and community benefit provided by Banner from 2000 to 2004:

YEAR	AMOUNT OF CHARITY CARE	COMBINED CHARITY CARE AND COMMUNITY BENEFIT
2000	$30,816,989	$49,326,000
2001	36,402,059	60,545,000
2002	53,511,499	67,342,000
2003	52,140,939	78,155,000
2004	48,269,761	89,175,000

The letter requested charity care information going back ten years and 25 years. As noted in the cover letter to these responses, Banner is the result of the acquisition of Samaritan Health System by Lutheran Health Systems in 1999. Prior to that date, the two companies either recorded charity care and community benefit inconsistently from year-to-year and with each other, or failed to record an amount for these items at all. The two companies also did not consistently report the amount of charity care separately from the aggregate reported amount of community benefit. Hence, it is not possible to provide a meaningful comparison of the amount of charity care provided by Samaritan and Lutheran in 1995 and 1980 with the amount of charity care that has been provided by Banner since 2000.

The implementation in Arizona in late 2001 of Proposition 204, which expanded eligibility under the Arizona Health Care Cost Containment System (Arizona's version of Medicaid) to persons earning 100% of the federal poverty level, is believed to have slowed the increase in reported "charity care" as more individuals who would have qualified for financial assistance instead became qualified under AHCCCS. Currently, about 24% of the persons enrolled in the AHCCCS program are eligible as the result of the eligibility expansion enacted by Proposition 204; individuals eligible for such coverage would also have been eligible for charity care under Banner's policies. Also, we believe that the amount of charity care also decreased from 2003 to 2004 in part because of the discontinuance of the Arizona State Emergency Services ("SES") program. This program funded physician services for certain categories of undocumented or nonqualified aliens, and Banner had been classifying the charges for hospital care provided to these individuals as charity care if they qualified under the SES program. With the discontinuation of the program, we believe, a number of the persons who otherwise would have qualified under the SES program are now declining to apply for financial assistance under the Banner policies and are therefore no longer classified as charity care by Banner.

A substantial portion of the community benefit reported by Banner consists of losses incurred by Banner facilities on care provided to persons qualifying for the Arizona Health Care Cost Containment Program or other state Medicaid programs. Banner

believes that it is important to its mission to serve persons whose care is funded by AHCCCS or Medicaid in the same manner as all other persons in need of medical care. Unfortunately, the challenges to state funding of Medicaid programs, fueled in part by the rapid rise in Medicaid enrollments[3], has resulted in reimbursement that has failed to keep pace with the rising cost of hospital care, which has caused substantial losses on Medicaid/AHCCCS services (measured on the basis of AHCCCS/Medicaid net patient revenue and costs allocated to services provided to AHCCCS/Medicaid patients). In 2004, Banner's net loss on medical services provided to AHCCCS/Medicaid patients was $32,262,390.

3. What percentage of your patients for your most recent fiscal year were: (a) uninsured, (b) covered by Medicare, (c) covered by Medicaid or other state or other governmental program providing medical care benefits for low income individuals, or (d) otherwise covered by private insurance?

Response:
The following table sets forth for 2004 the percentages of Banner's registered patients, both inpatient and outpatient, covered by various forms of third party payor coverage, and those without any known third party coverage:

TYPE OF PAYOR/UNINSURED	PERCENTAGE OF CASES*
Uninsured	7%
Medicare (includes Medicare + Choice)	27
Medicaid/Arizona Health Care Cost Containment System	18
Other Third Party Payor Coverage (includes Workers Compensation and Champus/TriCare)	49
TOTAL	100%

* "Cases" is defined to mean registration (for outpatient) and admissions (for inpatient).

4. Does your hospital ever agree to waive its fees immediately upon admission of a patient? If so, under what circumstances?

Response: Banner facilities will waive fees immediately upon admission only if a patient has pre-qualified for financial assistance under one of the programs described in Response No. 1 above, receives an Emergency Rating under the Colorado Indigent Care Program (Colorado facilities only) or if the patient is being readmitted and Banner's Risk Management or the hospital's Patient Services Departments have directed that the fees be

[3] From January 1, 2000 to January 1, 2005, enrollment in the Arizona Health Care Cost Containment System alone increased by 88% from 552,077 to 1,040,138. As of July 1, 2004, the total population of Arizona was estimated to be approximately 5,830,000.

waived in connection with medical care being provided to rectify a prior mistake or service error.

5. What effect, if any, has the increase in patient co-payments and deductibles had on patient bad debt writeoffs of your hospital over the past five years?

Response: Banner has experienced a steady increase in bad debt levels over the past five years from $143,106,000 in 2000 to $212,829,000 in 2004, although bad debt expressed as a percentage of revenue has ranged between 8.1% and 8.7% of total revenue over this period.[4] This steady increase is believed to be caused by a number of reasons, including a relatively high percentage of uninsured persons in the service areas of certain Banner facilities, and the increase in co-payments and deductibles. In 2004, approximately 40% of co-payments and deductibles for patients covered by private health insurance were uncollectible; hence, as the percentage of patient accounts covered by co-payments and deductibles increases, Banner expects the level of bad debt to increase as well.

6. Has your hospital or other members of your hospital system group entered into joint ventures with other nonprofit, tax-exempt hospitals to provide charity care or health care services? If so, please describe the nature of such joint ventures.

Response: Banner is a 50% member of City of Hope Samaritan, LLC, an Arizona limited liability company having City of Hope National Medical Center, another nonprofit tax-exempt hospital organization as the other member. This joint venture was formed in 1997 in order to establish a bone marrow transplant program at Banner Good Samaritan Medical Center in Phoenix, Arizona. Banner entered into this joint venture in order to make available advanced bone marrow transplant treatment for cancer in the Phoenix metropolitan area, using the clinical expertise of the City of Hope National Medical Center.

7. Has your hospital or other members of your hospital system group entered into joint ventures with physicians or other for-profit companies or investors to conduct unrelated trade or business activities? If so, please describe the nature of such joint ventures.

Response: Because this question and Question A.8 draw a somewhat artificial distinction between joint ventures that involve unrelated trade or business activities (which depends in part upon how a given joint venture is organized and operated), and joint ventures that conduct health care activities that are substantially related to Banner's "core" charitable mission, the response to this question is given together with the response to Question A.8.

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[4] Bad debt is recorded on the basis of usual and customary, or "chargemaster" charges for the services rendered, except that defaulted co-pays and deductibles are recorded on the basis of the amount of such co-pay or deductible.

8. Has your hospital or other members of your hospital system group entered into joint ventures with physicians or other for-profit companies or investors to conduct health care activities you consider to be substantially related to your core charitable mission? If so, please describe the nature of such joint ventures.

Response: Neither this question nor Question No. A.7 set forth a timeframe. Accordingly, Banner is responding with respect to joint ventures of which it has been a member since January 1, 2004.

The following are the joint ventures in which Banner has participated since January 1, 2004, and the manner in which Banner has treated the income from these joint ventures: [5]

(a) Sonora Quest Laboratories, LLC. This is a joint venture formed in 1997, in which Banner holds a 51% interest, and a subsidiary of Quest Diagnostics, Inc. holds a 49% interest. SQL provides a broad range of clinical reference laboratory services to physicians, hospitals and other health care providers, primarily in Arizona. The joint venture involved the consolidation of clinical reference laboratory operations already in operation by Quest Diagnostics and Samaritan Health System. The resulting organization has improved the efficiency, timing and quality of the clinical laboratory services. Except for a percentage of the income derived from laboratory services performed by SQL for Banner facility patients (which would, if performed by Banner itself, be treated as income substantially related to Banner's exempt purposes), Banner reports its share of the income derived from SQL as taxable income unrelated to its exempt purpose because clinical reference laboratory services, alone, are not recognized by the IRS as a basis for tax exemption.

(b) Banner Surgery Centers, LLC. Banner Surgery Centers LLC ("BSC") was formed in 1995 as a joint venture between Samaritan Health System and the corporate predecessor of Triad Hospitals, Inc., a for-profit hospital company. Samaritan's participation in the joint venture was motivated in large part by the desire to gain access to the expertise and experience that Triad's predecessor had demonstrated in establishing ambulatory surgery centers with higher quality, greater efficiency and greater patient satisfaction than those then being operated by Samaritan. Until May 2005, Banner held a 49% interest in the joint venture, but held 50% of the governing board seats and substantial control over the management and operation of the surgery centers. In May 2005, Banner acquired Triad's interest in BSC, and now owns 100% of BSC. Beginning in 1999, in response to rising competition in the ambulatory surgery center market, and to increasing physician requests for equity ownership, BSC began to transfer individual surgery centers to subsidiary limited partnerships, and to offer limited partnership

[5] All of the joint ventures (except the Loveland Medical Enterprises, LLC joint venture, which was not then in existence), and the tax treatment given by Banner to the income derived therefrom, were specifically examined by the Internal Revenue Service in the recently completed comprehensive audit, and no issues were raised by the IRS with respect to the impact of such joint ventures upon Banner's status as an exempt organization described in Section 501(c)(3) or Banner's treatment of the income derived from them.

interests for purchase by physicians who practiced in those surgery centers. Today, BSC owns 100% of two surgery centers in the Phoenix area, and is the majority owner (with interests ranging from 73.6% to 96%) and sole general partner of six other Phoenix area surgery centers. For years prior to 2005, Banner has reported its share of income from surgery centers owned entirely by BSC as exempt income related to its exempt purpose, and reported its share of the income from the surgery centers owned by the limited partnerships as taxable income unrelated to its exempt purpose because of Banner's attenuated control over those limited partnerships.

(c) Skyline Center for Health. This is an ambulatory medical campus in Loveland, Colorado, that is owned by Loveland Medical Enterprises, LLC ("LME"), a joint venture having Banner and various physicians and groups of physicians as its members. Banner owns a 35% interest in the LME joint venture. LME leases space in the campus to a number of other joint ventures that provide ambulatory services on the campus. Banner owns minority interests ranging from 20% to 40% in the joint ventures that provide outpatient surgery, endoscopy, imaging and MRI services on the Skyline campus. LME and the various services joint ventures began operations in December 2004. Because it is a minority member without unrestricted control over the operations of LME and the other joint ventures, Banner intends to report the income derived from LME and the other joint ventures as taxable income unrelated to its exempt purpose.

(d) Mountain View Surgery Center. Banner held a 66% interest in this joint venture which operated an ambulatory surgery center on the campus of McKee Medical Center in Loveland, Colorado, with the remaining interests held by physicians who practice at the surgery center. The joint venture was dissolved in 2004 in anticipation of the impact of the opening of the Skyline Center for Health, and Banner incorporated the site of the surgery center into ongoing expansion of McKee Medical Center. Because of its control over the operation of the joint venture, Banner reported the income derived from this joint venture as exempt income related to its exempt purpose.

(e) Rocky Mountain Radiology Center, LLC. This joint venture was initially formed with local radiologists and NCMC, Inc. (a nonprofit, 501(c) (3) organization and the owner of North Colorado Medical Center, which is leased to Banner) to acquire and operate an open MRI service in Loveland, Colorado. The joint venture was dissolved in 2004, and the aging MRI machine was purchased by the remaining physician investors for the appraised fair market value of the equipment. Banner owned a 25.5% interest in this joint venture. Because Banner and NCMC owned a majority interest and joint control over the joint venture, Banner reported the income derived from this joint venture as exempt income related to its exempt purpose.

(f) Banner Physician Hospital Organization. This is a taxable nonprofit corporation formed in 1989 to engage in risk-based joint contracting with commercial payors on behalf of a network comprised of certain Banner hospitals in the Phoenix metropolitan area and a number of primary care and specialist physicians. Banner controls half of the voting power on the governing board of this entity; the balance of the governing board is controlled by physician members of the corporation. The entity

contracts with commercial payors, and subcontracts with Banner, the participating physicians, and other providers to provide health care services to persons covered by the commercial payors. It operates on a break-even basis, and revenue received by Banner from the organization under the subcontract is treated as exempt patient revenue related to Banner's exempt purpose. Banner also contracts with this organization to perform third party administrator services for Banner's self-insured employee health plans.

(g) Mountain Shadows Medical Association. This is a taxable nonprofit corporation that operates in Loveland, Colorado in substantially the same manner as the Banner Physician Hospital Organization described above. Revenue received by Banner from this entity under its subcontract is treated as exempt patient revenue.

9. Do any of your hospital or hospital system joint ventures have charity care policies that require certain types or amounts of charity care to be provided? If so, please describe such policies, and how they are similar to or different from your hospital's charity care policy. Also explain the role your hospital has in assuring that the charity care policy of the joint venture is enforced. If your organization does not track charity care expense by such categories, please explain why not and provide a narrative response that explains whether there are certain categories of care for which charity care is more important or is not relevant.

Response: Banner's role in requiring and enforcing charity care policies to be adopted and implemented varies depending upon the type of joint venture, the degree of control exercised by Banner over the activities of the joint venture, the nature of the underlying activity of the joint venture, and whether the underlying activity would be exempt activity if owned entirely by Banner. For instance, the issue of charity care is irrelevant to the two physician hospital organizations because their purpose is to enter into global, clinically integrated or risk-based contracting with commercial payors. Similarly, the clinical reference laboratory business is not recognized by the IRS as an exempt business function, and therefore is not treated as a tax-exempt, charitable function by Banner (except for reference laboratory services performed for patients in Banner facilities or clinics, in which event such laboratory services are covered by Banner's general financial assistance policies). Banner's minority ownership position in the physician-driven joint ventures at Skyline Medical Center does not give it the power to exercise control over the charity care policies of those entities. It should also be noted that all of the services available at the Skyline Medical Center are also available at nearby McKee Medical Center, and are provided at that hospital subject to the Banner charity care policies described above.

Banner has, however, exercised a role in applying and enforcing charity care policies for the ambulatory surgery centers owned by the now-dissolved Mountain View Surgery Center (which applied the general Banner policy), and the surgery centers owned or controlled by Banner Surgery Centers, LLC. While Triad was a member of BSC, the Operating Agreement for BSC recognized that Banner and its representatives were obligated to act exclusively in furtherance of charitable exempt purposes, and required BSC to adopt a charity care policy consistent with Banner's exempt mission and

purposes. Accordingly, BSC has maintained a charity care policy providing that families with household incomes of less than 200% of the federal poverty level are eligible for charity care, as are patients falling within certain other hardship categories.

In evaluating the extent of charity care at ambulatory facilities, such as the BSC surgery centers, it must be kept in mind that BSC facilities perform elective outpatient surgery. Because of its elective nature, this type of service is provided far less frequently on a charitable basis than traditional inpatient hospital care, even when such elective services are provided within a tax-exempt healthcare facility. In part, this is because elective cases require that a physician be arranged for by the patient in advance of the procedure, whereas under Banner's physician on-call program, Banner arranges for a physician for patients requiring services that come in through Banner's emergency departments, which is where most patients receiving charity care enter the facility. In this regard, it should again be noted that Banner's participation and oversight over the charity care provided at the BSC surgery centers was specifically examined by the IRS in the recently completed audit, and neither Banner's participation in BSC nor Banner's treatment of the income received from the surgery centers were challenged.

10. Please respond to the following assertion: Many nonprofit, tax-exempt hospitals engage in joint ventures that shift the most profitable and valuable procedures, practices, and income streams to the joint ventures so that the greater profits and value may be shared with physicians and other for-profit persons.

Response: Banner believes that the statement describes a market dynamic that threatens the financial viability of the safety net provided by the nonprofit hospitals of this country, but misstates the motivation of most hospital systems (and certainly the motivation of Banner) that enter into such joint ventures. We believe that this situation is the result of the interplay of a governmental reimbursement system that provides relatively high margin reimbursements for certain types of procedures, and a statutory structure that authorizes physician ownership in many of these high-margin lines of business. Recognizing the primary role that physicians play in determining where their patients are referred for their healthcare needs, niche companies and equipment vendors encourage physicians to invest in specialty hospitals and freestanding specialty ambulatory centers in order to capitalize on the relatively high margin services. The unstated expectation is that physicians, acting out of their economic self-interest, will refer their patients to such specialty hospitals and ambulatory centers. The result, of course, is that these high-margin services migrate out of the nonprofit community hospital into the physician joint venture setting, sometimes in conjunction with increased utilization by physician-investors responding to the unstated financial incentive. The profits generated from the services are distributed to the physicians and the shareholders of the niche company instead of being used by the nonprofit community hospital to subsidize less remunerative services, charity care, maintain adequate staff and reinvestment in plant and technology. This "cherry-picking" scenario has been documented repeatedly, most recently in MedPAC's Report to Congress: Physician-Owned Specialty Hospitals, March 2005, and CMS' Study of Physician Owned Specialty Hospitals, May 2005. See also, Government Accountability Office, GAO-04-167,

Specialty Hospitals: Geographic Location, Services Provided and Financial Performance, October 2003. For these reasons, Banner strongly supports the Hospital Fair Competition Act of 2005, and is encouraged by the leadership shown by Senators Grassley and Baucus in this area. We also encourage CMS and MedPAC to continue to examine the disparities in reimbursement that make specialty hospitals and freestanding centers in high-margin service lines so attractive to physician investors.

At the same time, we believe that the statement misses the mark as to the motivation for nonprofit hospitals for entering into such joint ventures. While we cannot say whether "many" nonprofit hospitals have elected to participate in such joint ventures, we believe that few, if any, have done so for the purpose of sharing "the greater profits and value" with physicians and other for-profit persons. Rather, it has been our experience that nonprofit hospitals that have entered into such joint ventures have done so in response to the plans by physicians to establish competing high-margin business ventures, often with capital provided by the niche company. Faced with the prospect of losing whole service lines to physician-driven competitive specialty providers supported by the referrals of the investor physicians' patients, the local community nonprofit hospitals are forced to respond with their own joint venture opportunities for physicians. In short, such joint ventures are, in our experience, nearly always entered into as defensive responses to the threat of physician-owned specialty provider competition.

11. How do you assure that your joint ventures with others do not deplete your hospital's resources that otherwise would be available for charity care, such as by tying up cash and other liquid assets in the investments in the joint venture?

Response: Banner's investments in joint ventures are considered to be capital expenditures, and any joint venture opportunities are evaluated in comparison to other capital expenditure opportunities, such as new or expanded facilities or technology, within Banner's annual capital budget, which is determined primarily based upon the amount of cash flow generated by the company's operations. Hence, there is no diversion from the operating budget that would be used to fund charity care. Furthermore, Banner generally does not enter into joint ventures on financial terms different from the terms offered to other investors, so that the capital contributed by Banner is proportionate to the equity interest held by Banner in the joint venture. Finally, Banner applies the same criteria in evaluating a joint venture opportunity as it would to its own investments, and expects positive net income and positive cash flow from such investments. Accordingly, Banner would not invest in a joint venture that was projected to suffer losses and/or negative cash flow (nor, for that matter, would such a joint venture be an attractive investment for physicians or other for-profit entities).

12. Please provide a charity care breakdown for each entity that is a member of your hospital system group. In your opinion, should charity care be measured on an aggregate group basis or on an organization-by-organization basis?

Response: All of Banner's hospitals and facilities, except the joint ventures, are operated by a single entity, Banner Health, an Arizona nonprofit corporation. IRS

guidance permits the community benefit assessment of an exempt organization's activities to be assessed on an aggregate basis. We believe that this is the correct approach.

13. In your judgment, should the Federal tax law require each joint venture in which a tax-exempt hospital participates to have a charity care requirement? If so, should the amount of the requirement differ depending upon the extent of ownership by exempt hospitals in the joint venture?

Response: We do not believe that Federal tax law should require each joint venture in which a tax-exempt hospital participates to have a charity requirement because: (1) the IRS community benefit standard for tax-exemption for hospitals does not mandate a charity care requirement, (2) the nature of the business conducted by the joint venture may constitute taxable activity that is not eligible for tax-exempt treatment, the IRS does not prohibit exempt organizations from directly conducting limited amounts of such taxable unrelated trade and business activity, and therefore the IRS should not prohibit exempt hospital organizations from doing so through joint ventures, and (3) the opportunity for exempt hospital organizations to have a controlling interest sufficient to impose a charity care requirement upon joint ventures may not exist where hospitals are participating in physician-driven joint ventures for defensive reasons, as described in Response A.10 above.

14. How does your hospital account for charity care provided by a joint venture in which the hospital participates? For example, if your hospital is a 50% owner of a joint venture, and the joint venture provides $100 of charity care, do you count $0, $50, $100, or some other amount, as charity care provided directly by your hospital?

Response: In general, the accounting for charity care will be driven by the accounting treatment accorded to Banner's interest in the joint venture. If the joint venture is accounted for using the equity method under generally accepted accounting principles (as was Banner Surgery Centers, LLC until May 2005), then none of the charity provided by the joint venture will be reported by Banner. If the joint venture is accounted for on a consolidated basis (as is Sonora Quest Laboratories LLC), then all of the charity care would be reported on Banner's internal financial statements as would all other items of revenue and expense.[6]

15. What types of research and teaching are performed by your hospital as a charitable or educational activity?

Response: Banner supports medical education and research in many ways as educational or charitable activities. These include the following:

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[6] It should be kept in mind, however, that because charity care is care provided without any intent to pursue collection, neither the revenues represented by the amount of care provided nor the write-off of those revenues appear on Banner's external audited financial statements, as per GAAP.

- Financial and administrative support of medical residency and fellowship programs over and above the current government funding. The total number of residents and fellows in the programs at Banner Good Samaritan Medical Center and North Colorado Medical Center is approximately 254, with government funding of the programs limited to a portion of the costs associated with approximately half the positions and with other outside funding also limited. In 2004, Banner subsidized medical education in the amount of $2,950,589.
- Collaborative agreements with the Phoenix VA Hospital and Phoenix Children's Hospital to provide an integrated teaching program for residents and fellows in internal medicine and surgical specialties, including much of the administrative support structure for the VA program.
- Collaborative agreement with the University of Arizona to provide teaching facilities, faculty members, and a supervised patient care environment for approximately 50% of all 3rd and 4th year U of A medical students and for a select group of 4th year students from other universities around the country.
- Collaborative relationship with Arizona State University and Phoenix-area Community Colleges to provide teaching facilities and supervision of nursing students.
- Several educational assistance and scholarship programs provided for nursing and allied health professionals, including a special program designed to increase the number of nurses fluent in English and Spanish to meet the unique needs of the populations served by Banner.
- Collaborative relationship with Phoenix-area communities and fire departments to provide teaching facilities and supervision of emergency medical personnel.
- Collaborative agreements with other not-for-profit institutions to provide resident physicians and supervising faculty to serve under-served populations in Arizona and Alaska, including at Native American hospital facilities.
- Participation and support in the Arizona Medical Education Consortium.
- University of Alaska Anchorage – Develop, maintains and actively supports with financial contributions the nursing expansion program.
- University of Alaska Fairbanks – Collaborate on the new Radiology Technologist program that offers a technical and clinical education to a select group of sponsored students.
- Funding of psychiatric resident rotation in Fairbanks from University of Washington Psychiatric Residency Program.
- University of Northern Colorado School of Nursing – Partnership
- WWAMI (named for the participating states of Washington, Wyoming, Alaska, Montana & Idaho) Program – Sponsor medical students from the University of Washington School of Medicine to spread medical care, consultation, and education opportunities across a five-state medical education network. WWAMI students receive instruction in the surgical field at FMH, experience all types of surgery.
- Support for Fairbanks Area Health Education Center, including increased clinical rotations and preceptor training in partnership with University of Alaska College of Rural Health.

- As part of its participation with the CMS Rural Community Demonstration Program, Banner Churchill Community Hospital in Fallon, Nevada, funds a fulltime nursing instructor for Western Nevada Community College for a nursing program targeted to students from rural areas, and subsidizes an instructional site for this nursing program.

In addition to the medical education activities, the research activities supported by Banner include the following:

- Nursing and therapy studies including projects to support magnet status, to contribute to nursing higher education and advanced degrees, to evaluate quality of care and current practice patterns, to influence and improve patient care in Banner facilities as well as the community.

- Medical Education research including projects that contribute to the body of toxicology and poison control information, promote scholarly activity in our fellowship programs (cardiovascular, maternal-fetal medicine, toxicology), evaluate and improve medical education curriculum, create database information for disease and risk factor tracking.

- Alternative therapy research including music therapy, aroma therapy, acupuncture, energy healing to discover new potentially efficacious alternative therapies to treat symptoms and disease.

- Physician initiated research including retrospective chart reviews for data collection, novel device experimentation, treatment protocol development, diagnostic testing evaluation and application in alternative settings, seed projects to generate grant funding, and project development within the blood conservation program. Physician initiated research efforts in movement disorders by Drs. Abbas, Samanta and Mahant are focused to improve clinical utilization of deep brain stimulation technology for individuals with Parkinson's Disease.

- Community and public health projects to contribute to large health organization databases working toward improved health care and services within the community.

- Banner Research joint venture with the City of Hope in Duarte, California to allow patients in our community access to treatment protocols being evaluated for efficacy outcomes in the treatment of hematological cancers.

- Banner Research relationship with the National Cancer Institute via the CCOP in Phoenix and Alaska to allow community physicians and their patients access to protocols evaluating efficacy outcomes in the treatment of cancer, protocols assessing various modalities to control the symptoms of cancer and its treatment, and protocols examining methods to prevent cancer. Patients and individuals at an

increased risk for cancer from around the state of Arizona, central Alaska and in northern Colorado have had the opportunity to participate in novel and innovative clinical trials through this mechanism. Patient, family, and community education on cancer clinical trials is also a component of this program. Outreach efforts connected with this research program include cancer prevention studies extending to rural communities such as Yuma, Sedona and Kingman.

- Banner Research support of cell and isolet research with Banner's hospital-based clinical laboratories promoting development of new testing methodologies, surveillance of changes in local and regional drug resistance, and work with the Translational Genomics Institute in tissue assays seeking genetic markers in cancer and other diseases. Specific examples of the impact of these projects include:

    - Surveillance studies (multiple/year over past 8 years) of bacterial resistance to antimicrobial agents (antibiotics) in the community. Information shared with community clinicians as well as the Arizona Department of Health Services to help guide empiric treatment regimens.
    - Work with Arizona Department of Health Services in education of clinicians in appropriate use of antimicrobial agents throughout the State of Arizona using research data and promoting better patient outcomes in community.
    - Work with the Arizona Department of Health Services in education of laboratories throughout the state in appropriate methods for testing of organisms for resistance to antimicrobial agents.
    - Collaborating with Translational Genomics Institute, a nonprofit research organization, to find new rapid molecular methods to expedite diagnosis of infectious diseases in the community thus promoting better patient outcomes.
    - Collaborating with Valley Fever Center of Excellence at the University of Arizona in evaluating and standardizing diagnostic methods for Valley Fever, an endemic fungal disease, as well as educating the public.
    - Collaborating with Translational Genomics Institute on tissue studies of cancer to find novel diagnostic tools for cancer in the community.

- PET imaging studies and analysis research as part of the Banner Alzheimer's Disease and Research Center, developing advanced usage of PET in the early detection and diagnosis of Alzheimer's Disease. Dr. Eric Reiman served as an expert consultant to the Centers for Medicare and Medicaid services and the National Institute on Aging culminating in the successful CMS approval of PET imaging as useful in the clinical diagnosis of Alzheimer's Disease in those patients who have had a comprehensive medical work-up and in whom the diagnosis remained uncertain. Dr. Reiman's team is currently focusing their research efforts on working with the local Latino population, so that results generated from his longitudinal aging and Alzheimer's Disease projects can be utilized by the Latino community with respect to early detection, prevention, and

diagnosis. Other research projects determine the effects of diet and exercise in the maintenance of brain health and possibility that life-style behaviors may delay the onset of Alzheimer's disease.

- The Clinical Neurobiology and Bioengineering Research Center (CNBRC) current research focus is on spinal cord injury and methods and device evaluation for promoting ambulation as well as technology development to promote health and recovery of function after spinal cord injury and stroke. We are also enhancing our bioengineering focus with the addition of a state of the art gait analysis and locomotion laboratory.

- Multiple nursing/health clinical research studies conducted in affiliation with University of North Colorado on wide variety of clinical care areas, supported by Banner.

16. Please describe any fund-raising activities conducted by your hospital in an attempt to supplement fees for services and other revenues. Specifically, provide for the last three years the amount of charitable donations received by your hospital. Does your organization ever conduct fund-raising activities which commit the donations raised by the activity to be used to provide medical care to low-income or uninsured individuals or families?

Response: Banner Health Foundation is a supporting organization for Banner Health, and conducts a variety of philanthropic fund-raising activities, including special events, planned giving, and direct solicitation. These fund-raising efforts cover a wide range of Banner activities, from donations to support the construction and equipping of new facilities and services, nursing and other healthcare professional education, and specific clinical activities and services. The total amounts of donations received by the Banner Health Foundation in 2002, 2003 and 2004, were $3,839,474, $4,935,817 and $6,435,810, respectively.

At least three specific fund-raising efforts supported by the Banner Health Foundation are targeted towards the provision of medical care to low-income and uninsured individuals and families. The first is support received for the Laura Drier Breast Center at Banner Good Samaritan Medical Center to provide free mammograms to low-income minority women. The second is fund-raising obtained to support 19 school-based clinics funded and staffed by Banner which provide needed health care for low-income students at over 100 schools in the Phoenix metropolitan area. The third program raises financial assistance for children and adolescents admitted to the Wendy Paine O'Brien Unit at Banner Scottsdale Behavioral Hospital to enable the patients to complete their treatment.

17. In general, does partnering with for-profits in a joint venture arrangement have implications on the provision of charity care and the satisfaction of the community

benefit standard by the joint venture or by the overall hospital system that participates in the joint venture?

Response: Generally, the answer to this question is no. Of course, under current IRS standards, the answer will depend upon the manner in which joint ventures are organized and operated, the nature of the activity conducted by the joint venture, and the extent of the exempt organization's control over the joint venture. See generally Responses A.7-A.13.

18. Do your compensation arrangements with physicians and other professionals in any way encourage or discourage the provision of charity care by your hospital or hospital system? If so, how?

Response: Generally, the answer to this question is no. Most physicians who practice in Banner hospitals are independent community physicians who are not compensated by Banner. However, hospital based physicians who are given either exclusive contracts, such as radiologists, emergency physicians, and pathologists, or to provide back-up coverage for certain lines of service for unassigned patients, such as certain anesthesiologists, intensivists, and hospitalists, are required under such contracts to provide care to all patients presenting at Banner hospitals who require their services. Although these physicians may bill independently for these services, their agreements with Banner ensure that the patients will have access to physician services. Similarly, Banner has entered into a number of direct and indirect arrangements with specialist physicians under which Banner pays, or guarantees payment, to these physicians for services provided to all persons who require emergency services or immediate follow-up services by a specialist. These payment arrangements became necessary because increasing numbers of specialists were refusing to provide unpaid emergency department call coverage, in part because of the rising levels of uninsured patients, and were resigning from hospital medical staffs rather than taking call. While these arrangements do not preclude the physician from billing the patients, the compensation arrangement helps ensure that patients will have access to necessary physician services that would otherwise not be available to them.

19. Please provide a breakdown of your charity care expenditures, across emergency room services, urgent care services, intensive care services, rehabilitation, maternity care, mental health care, cosmetic surgery, chemical dependency and outreach, and any other categories you consider to be appropriate.

Response: In response to other questions above, Banner has provided numerous examples of the types of expenditures Banner incurs with respect to charity care. For reasons set forth in Response No. B.20 below, Banner believes that most persons receiving charity care do so via Banner's emergency departments. However, Banner cannot break down its charity care activity in the manner requested except by means of a manual examination of each of the thousands of individual patient accounts that are classified as charity accounts in order to identify the services provided on those individual accounts.

20. What kind of community outreach and education activities does your hospital conduct, and how much is expended on such activities (in absolute dollars and as a percent of your budget)?

Response: Banner is engaged in a wide variety of community outreach and education activities. Many of these activities are developed on a local basis by hospital management and local hospital community boards in response to community needs and interests; others involve sponsorship of local programs that support improved health care. In addition to the activities described in the foregoing responses, the following is a partial list of these activities:

COMMUNITY PROJECTS

- **Banner Health Call Center/Helpline**

In 2004, the BH Call Center handled 154,522 phone calls for physician referral, information on BH programs and services and health-information provided by registered nurses. Almost 75 percent of the calls were from low-income people who do not know where to turn for health advice and services. Counselors at the **Banner Health Helpline** took 82,861 calls in 2004 for behavioral health help or information.

- **Banner Poison Control Center**

The **Banner Poison Control Center** nurses received more than 101,129 calls in 2004 year for medical advice on possible poisonings and insect and snakebites. In addition, the center provides extensive community education on prevention of poisonings.

- **Healthy Beginnings Prenatal Program**

Healthy Beginnings is a Loveland, Colorado community-based prenatal program that assists expectant mothers who have little or no insurance coverage. The program helps women access quality prenatal care and education.

- **HomeBase Youth Services**

HomeBase Youth Services, a program founded in 1994 provides shelter, counseling, healthcare, education, outreach services and guidance to the 5,000 runaway homeless youth of Phoenix. BH provides free medical care to HomeBase, supports the program through a contribution which is matched by the Arizona Republic and leases a building to HomeBase for its Outreach Center at 1244 E. McDowell Road in Phoenix for $1 a year. The Center serves as a place where homeless youngsters can sleep, take a shower, have a meal, talk to a counselor, place a phone call home and get assistance to get off the streets and into a safe environment. The Center also supplies an outreach van with food, blankets, socks, toiletries and medicine to help youth living on the streets.

- **Junior Achievement**

BH is an annual major sponsor of the Junior Achievement program in grammar schools. Each year over the past eight years BH hospitals have "adopted" elementary schools in

their respective areas and have sent volunteers into the schools to serve as community role models and teach basic business concepts.

- **Kid-Self Pediatric Therapy Program**

The Kid-Self program serves young children in Loveland experiencing physical, developmental and communication difficulties, whose parents do not have insurance coverage or are unable to afford the cost of therapies for their child. Physical, occupational and speech/language therapy are provided through the program.

- **Loveland Community Health Center (LCHC)**

LCHC provides quality, comprehensive health care for uninsured and underinsured community members. McKee Medical Center provides the physical facility, expansion and supplies, while the Sunrise Group of Greeley provides staffing for the medical clinic.

- **Mission of Mercy Mobile Medical Van**

Mission of Mercy is a mobile medical clinic launched in 1997 that serves the more than 200,000 uninsured working poor in Phoenix and the surrounding cities that make up Maricopa County. The rolling clinic is supported entirely by volunteer labor and donated supplies. More than 15 BH nurses and physicians volunteer their time and expertise to help those who turn to Mission of Mercy because they cannot afford medical care. One of the largest donations comes from Sonora Quest Laboratories, which provides free laboratory work for the Mission's patients. BH has written many grants on behalf of Mission of Mercy and has provided funding for the clinic.

- **Prescription Assistance Program**

McKee Medical Center's Care Coordination department assists elderly and low-income community members in accessing assistance for their prescription medication.

- **School-Based Health Clinics**

The Banner Health School-Based health clinic (SBHC) program provides primary care services to uninsured children enrolled in schools throughout Chandler, Glendale, Mesa, Phoenix and Tempe. Lack of health services to uninsured children is a critical problem in Arizona, where a significant portion of children are without health insurance. The program's goal is to keep uninsured children healthy, in school, and out of the emergency room.

- **Susan G. Komen Foundation/ Phoenix Race for the Cure®**

With significant support from BH, The Komen Race for the Cure® Phoenix is held in October. In 2004, more than 35,000 participants raised in excess of $1,000,000 to eradicate breast cancer as a life-threatening disease by advancing research, education, screening and treatment. More than 3,000 persons comprised the BH team. In addition, Banner received a grant from the Komen Foundation to provide free mammography services at the Laura Dreier Breast Center.

COMMUNITY EDUCATION AND WELLNESS PROGRAMS

BEHAVIORAL HEALTH

- **The Golden Heart Project** "Off the Street and Into Treatment" – Lead by Fairbanks Memorial Hospital (FMH) and is made of community leaders in business, native organizations, the University, government, healthcare, justice and corrections, treatment services, and media. The project produces local systems changes to improve prevention, intervention, and treatment services with regard to the needs of the chronic inebriate population. This community group takes responsibility for improving access to appropriate treatment services and for changing pessimistic attitudes about the value of support behavioral treatment services.
- **National Anxiety Week/National Depression Week** – Provided screenings, educational materials and individual assessments offered to the community. (NCMC)

CANCER

- **American Cancer Society Daffodil Days** – Event sponsor (FMH)
- **American Cancer Society** "Relay for Life" event sponsor for Larimer, Morgan, Logan and Weld counties in Colorado – McKee, EMCH, SRM and NCMC event sponsors
- **American Cancer Society** "Relay for Life" event sponsor for Keith County, Nebraska – Ogallala Community Hospital
- **American Cancer Society** "Relay for Life" event sponsor for Maricopa County, Arizona – Banner Desert Medical Center
- **Cancer Navigator Program** – Service provided by BDMC
- **Interior Alaska Cancer Association** – Sponsor (FMH)
- **Komen Race for the Cure Northern Colorado** – Event sponsor
- **Skills for Healing** and **I can Cope workshops offered to cancer patients and caregivers** (BTMC)
- **Thunderbird high School Relay for Life-** Contribution made on behalf of 2004 Singer Award winner, Nancy Edgell.

CARDIAC

- **American Heart Association Phoenix Heart Walk/Heart Ball** – Event sponsor
- **American Heart Association Alaska Heart Walk** – Event sponsor (FMH)
- **Cardiac Rehabilitation Program** - In partnership with the American Heart Association, BH created a cardiac rehabilitation information program that can be used free at the Association's Halle Heart Center in Phoenix. The information includes a display, video and booklet.
- **Hearts for Arts** – Event sponsor (SRM)

COMMUNITY PARTNERSHIPS/COMMUNITY SUPPORT SERVICES

- **AHA Food Drive** – Page Hospital, in collaboration with Lake Powell Medical Center, collected and donated 900 pounds of food.
- **Air Life of Greeley** – Event sponsor (NCMC)
- **Alaska Society for Respiratory Care** – Event sponsor (FMH)
- **Anti-Defamation League** – Event sponsor
- **Annual Trivia Bowl Sponsor** - McKee
- **Arizona Chamber of Commerce** – Event sponsor
- **Arizona Coalition for Tomorrow** – Event sponsor
- **Arizona State University Foundation** – event sponsor
- **Arizona Town Hall** - Member
- **Arthritis Foundation** – course instruction
- **Artic Winter Games** – Major sponsor (FMH)
- **Association of the US Army** – Event sponsor (FMH)
- **Banner Mesa** – provides meeting space for a large number of non profit, community groups
- **Bike to Work** – event sponsor (NCMC)
- **Building a Healthier Mesa** –Banner Desert was actively involved in efforts to build a healthier community in Mesa.
- **Burn Unit Golf Tournament** – Event sponsor (NCMC)
- **Center for the Advancement of Small Business** – Event sponsor
- **Chamber of Commerce** – Event sponsor (FMH)
- **Children's Safety Fair** – Banner Thunderbird partnership with Cities of Peoria and Glendale.
- **City of Mesa's Tour de Culture** – health screenings provided by BBMC, BDMC and BMMC
- **City of Peoria Easter Egg Hunt** – Event sponsor
- **City Safe Program** – BTMC and City of Glendale partnership
- **Colorado Chill women's Basketball** – corporate sponsor (McKee)
- **Colorado Eagles Hockey Team** – McKee is a major corporate sponsor and provided first-aid stations and staff at various events.
- **Colorado Farm, Home and Garden Show** – Provided blood pressure screenings, burn prevention information and Air Life helicopter rides. (NCMC)
- **Community Classic Bike Tour** - McKee Medical Center is a major sponsor/planner of the yearly Community Classic Bike Tour. Proceeds from the yearly even benefit programs such as the Healthy Beginnings Prenatal Program.
- **Community Blood Draws** – Torrington Community Hospital performed over 3,000 draws in Torrington and surrounding communities
- **Community Health Fair** – Torrington Community Hospital sponsored annual health fair with 30 business partners and more than 1,000 community members in attendance.
- **Economic Club of Phoenix** – Event sponsor
- **Emergency Medical Services of Colorado** – Event sponsor
- **Fairbanks Counseling and Adoption** – Event sponsor of Mosquito Meander 5K Race (FMH)

- **Fighter Country Partnerships** – Contribution (BH/BEMC)
- **Friends of the Air Force Ball** – Event sponsor (FMH)
- **Glendale Chamber of Commerce** – Event sponsor (BTMC)
- **Glendale Glitters** – Event Sponsor (BTMC)
- **Glendale Summer Ball Program** - Event Sponsor (BTMC)
- **Greeley Independence Stampede** – Event sponsor (NCMC)
- **Greeley Philharmonic Orchestra concert** – Event sponsor (NCMC)
- **High Plains Chataqua Program** – Event sponsor (NCMC)
- **Holiday care packages** to soldiers oversees (BMMC)
- **Keith County Area Fireworks/Ogallala Volunteer Fire Department** – event sponsor (Ogallala Community Hospital)
- **Larimer, Morgan, Logan and Weld Country Fairs County Fairs** – McKee, EMCH, SRM and NCMC provide booths, blood pressure screenings and information.
- **Logan County Chamber of Commerce** – Member and event sponsor (SRM)
- **Logan County Fair** – Event sponsor (SRM)
- **Loveland Chamber of Commerce** – Member and event sponsor
- **Loveland Reporter-Herald Newspaper in Education** – Sponsor (McKee)
- **March of Dimes – Alaska** - Event sponsor (FMH)
- **March of Dimes – Arizona** – Event sponsor
- **March of Dimes – Colorado** – Event sponsor (NCMC)
- **Mesa Grande Alliance** – Banner Mesa Medical Center supported City of Mesa neighborhood grants, projects and events throughout the year.
- **Mesa Southwest Museum** – Partnership with the Museum, Banner Mesa Medical Center (BMMC), SRP and Southwest Ambulance. The partnership will create a Mesa Grande Archeological Observation site on Banner Mesa's 8th floor. In addition to the donated space, BMMC will provide volunteer docents.
- **Midnight Sun Run** – Major sponsor (FMH)
- **Midnight Sun Intertribal Powwow** – Event sponsor (FMH)
- **Multiple Sclerosis Society** – sponsor for MS Walk (FMH)
- **Ogallala Regional Arts Council** – member and events sponsor (Ogallala Community Hospital)
- **Page Attacks Trash** – Page Hospital employees volunteered to be area coordinators. This local clean up program has received recognition from President Bush, Sr. as one of his 2000 Points of Light.
- **Rotary Club** – member (McKee)
- **Paul L. Singer Awards** - These awards recognize BH Arizona employees for community service. In 2004, 66 employees were honored. Three of the honorees were selected as Paul Singer Award recipients. Donations are given to award winners charities.
- **Safe Haven** – Banner Thunderbird and Banner Mesa participate in the Safe Haven program for newborns
- **Safe Place** – Banner Thunderbird is a Safe Place location for HomeBase Youth Services
- **Sister City Program** – Provided healthcare services and surgical procedures to Caraz, Peru in bi-annual trips. (BMMC)

- **Special Olympics Alaska** – Event sponsor (FMH)
- **Sterling Community Health Fair** – Partnership (SRM)
- **St.** Matthew United Methodist Church (Sign Language Choir) - Contribution made on behalf of 2004 Singer Award winner, Michele Beaudry
- **Stroke Check Program** – Banner Thunderbird Medical Center, Banner Mesa Medical Center, Banner Baywood Medical Center event participants
- **Turkey Trot** - McKee Medical Center is a major sponsor/planner of this yearly Thanksgiving Day run/walk which as benefited groups such as the Kid-Self Pediatric Therapy Program and Healthy Beginnings Prenatal Program.
- **Trends Charities** – Event sponsor
- **UNC School of Nursing** – Contribution
- **United Way of Tanana Valley** – Sponsor for Day of Caring, Literacy Council and Center for Non-violent Living (FMH)
- **University of Fairbanks Alaska** – Provide assistant trainer services during the athletics season and a major corporate athletic sponsor. (FMH)
- **University of Northern Colorado Athlete Department** – Corporate Partner (NCMC)
- **Valley Interfaith Project** – Contribution
- **Verrado Community Opening Event** – Distribution of health information
- **Verrado in Motion** – Quarterly resident events
- **Walk from Obesity** – Event sponsors (BMMC and BGSMC)
- **West Mesa Community Development Corporation** – Banner Mesa supports this organization, and also leadership serves on their board
- **Windsor Chamber of Commerce** – Member and event sponsor
- **World Eskimo-Indian Olympics** – Event sponsor (FMH)
- **Yukon Quest International** – Event sponsor (FMH)

DIABETES

- **American Diabetes Association** – Sponsor (FMH, BTMC)

DISABILITIES

- **Banner Wheelchair Suns** – Banner Good Samaritan Medical Center, in partnership with the Phoenix Suns and America West Airlines, sponsors the Banner Wheelchair Suns, to raise awareness of the capabilities of disabled persons.
- **Wheelchair clinic with Home Health** – Provide free annual tune-ups for local wheelchair bound residents (FMH)

COMMUNITY EDUCATION

- **Air Life** – Provided presentations to various Colorado communities.
- **Alaska Health Fair** – Event sponsor (FMH)
- **COPD and Asthma Education Classes** – McKee Medical Center

- **COPD Awareness** – Banner Thunderbird sponsored an educational event featuring comedian Robert Klein.
- **Crossroads of Childhood Conference** – Banner Thunderbird co-sponsored the event with ASU West and donated 100 scholarships to those in need.
- **Free support groups** throughout the BH system helped hundreds of patients and families cope with cancer, arthritis, diabetes, heart disease, pulmonary disease, behavioral disorders and death.
- **Heal with Steel** – Banner Thunderbird sponsored this motorcycle run to benefit the Orthopedic Research and Education Foundation.
- **Job Shadows** – Encouraging healthcare careers through observation (FMH)
- **Literature distribution** at community wellness events.
- **Literacy Council** – Team sponsor (FMH)
- **Loveland Community Health Fair** – McKee Medical Center serves with other community organizations as a major sponsor of the yearly health fair. The fair provides free and low-cost screenings for a broad array of health-related conditions and offers education on numerous health issues. Approximately 1,300 community members attend the fair each year.
- **Nursing Scholarship Program** – Banner Thunderbird "Funds" (Volunteer Services) donated to the Glendale Community College and Arizona State University West nursing scholarship programs.
- **Rural Nursing Symposium for Northern California** – Banner Lassen Medical Center, event host and sponsor.
- **Safety and Injury Prevention** – McKee participates with other community agencies to provide safety and injury prevention education at the children's Safety Fair, Windsor/Severence Fire Department Open House and Wal-Mart Safety Days.
- **Sandhills Crisis Intervention Program** – golf tournament sponsor – Ogallala Community Hospital
- **Speakers Bureau** – Banner Desert Speakers Bureau provided more than 100 talks to community groups and senior centers. Banner Baywood Medical Center and Banner Baywood Heart Hospital offered nearly 50 presentations to members of the community interested in learning about everything from orthopedic surgery to heart-healthy eating. Speakers included physicians, nurses and other professionals from a variety of health care experience.
- Sponsored **local public television and radio** related to health issues (FMH) (NCMC)
- **Sun Safety Coalition** –sponsor (Banner Thunderbird)
- **Wellspring Health and Resource Libraries** – McKee and NCMC offers community members access to books, tapes, videos, journal articles, etc. on health-related topics.

<u>OLDER ADULTS</u>

- **Alaska International Senior Games** – Event sponsor (FMH)
- **Alzheimer's Association** - Corporate Sponsor for Memory Walk, Memories in the Making (BH, Ogallala Community Hospital)
- **Community Wellness Clinics** – A community wellness Registered Nurse conducts daily wellness clinics at senior community throughout the east valley (Banner Home Care)

- **Keith County Senior Center** – contributor (Ogallala Community Hospital)
- **Life Options** – Provide education and other health resources for Mesa seniors. This is a partnership with Mesa Community College, Mesa Senior Center and Mesa Public Library.
- **Meals for Seniors** – Program support (NCMC)
- **Mesa Senior Center** - Sponsor
- **Senior Health Fairs**

WOMEN'S ISSUES

- **Banner Good Samaritan's Women's Health Clinic** – Services provided to the community
- **Car Safety Seats** – Desert Samaritan checked 366 child safety seats, partnership with Governor's Office of Highway Safety and court system to offer "traffic school" for car seats.
- **Department of Health Tobacco Use Prevention Program** – Smoking Cessation program instruction
- **Fresh Start for Women** – One dollar per year lease of prime property
- **First Baby of the Year** – Stroller full of gifts donated from the community (FMH)
- **Low-Cost Mammography Screening Program** provided mammography screenings for women.
- **Mothers in Sympathy and Support** – Contribution made on behalf of 2004 Singer Award winner, Michele Beaudry.
- **Page Women's Shelter Work Program** – Page Hospital provided work experience for abused women.

WORKING POOR

- **Banner Good Samaritan's Outpatient Clinic** – Services provided to the community
- Working as teams, **BH departments** pooled resources to **provide food, clothing and gifts** for more than 100 needy families during the holiday season.
- **Glendale and Peoria Fire Departments** – Banner Thunderbird participated in an immunization program.
- **Habitat for Humanity** - Contribution
- **Sojourner Center of Phoenix** – Banner Thunderbird sponsored a clothing drive for new and gently used business attire for abused women.
- **Welcome to America Project** – contribution on behalf of 2004 Singer Award winner, Carolyn Manning
- **West Side Food Bank** – On going contributions (Banner Thunderbird)

YOUTH PROGRAMS

- **Alaska Home School Science Fair** – Microscope donation (FMH)
- **Alaska Youth Safety program** – Sponsor (FMH)
- **Boy Scouts** – event sponsor (NCMC); annual dinner sponsor (McKee)

- **Bicycle Safety** – Banner Desert distributed bike helmets to Title-One federally funded schools; taught 1,000 children the rules of the road with the Bicycle Safety City.
- **Better Schools, Better Communities** – NCMC partnered with Greeley Central High School
- **Building a Healthier Mesa**: Banner Desert is an active partner with various healthcare organizations, non-profit entities and the community's awareness, knowledge and readiness to become healthier.
- **Car Safety Seats** – Banner Children's Hospital checked hundreds of child safety seats, partnership with Governor's Office of Highway Safety and court system to offer "traffic school" for car seats.
- **Children's Action Alliance** – Contribution
- **Desert Sammy Health and Safety Education Program** - This Banner Children's Hospital based program provided hundreds of presentations to elementary school students in the East Valley during the school year. Topics included hygiene, bicycle safety, drug and alcohol awareness and firearm safety.
- **Dottie Kissinger Children's Camp (Banner Hospice Program)** – Provided support for a free bereavement camp near Saguaro Lake for children who have a lost a parent or loved one. Trained counselors work with 6 to 18 year olds and their parent or guardian to allow them to remember and heal.
- **Florence Crittenton** – Residential treatment center for teen mothers and their babies – Event sponsor
- **Growing Healthy Families Community Health Fair** – free event that provided car seat checks and other important health information for families in April on the Banner Mesa campus. Participants included Banner Mesa, Banner Desert and Banner Poison Center.
- **Heart Smart Day** - Torrington Community Hospital provided heart health education to fifth graders.
- **Healing the Children** – BDMC donated medical services for two children
- **Indian Health Services and Inter Tribal Council of Arizona**: Partnerships were formed to work with Native American communities on child passenger safety activities.
- **Little League sponsorships** - McKee
- **Logan County High Schools** – Sponsor of after-prom parties (SRM)
- **Newspapers In Education** – Providing newspapers for public school use (FMH)
- **NJC Athletics** –Sponsor and provided volunteer physicians at home games during sports season (SRM)
- **Ogallala and western Nebraska area high schools** – sponsor of post-prom alternative events (Ogallala Community Hospital)
- **Prevent Alcohol and Risk**-Related Trauma in Youth – McKee provides local high school students with a dramatic look at the effects of alcohol use and risk-taking behavior. The program is collaboration between McKee Medical Center, Thompson Valley Emergency Medical Services, Loveland Police Department and the Larimer County Coroner. It has been offered to Thompson R2J high school students since

1999. The first year of the program, 650 students participated. Since then, the number of youths participating each year has nearly doubled.

- **Prom-A-Rama** – event sponsor – the program provides high-school students with positive, alcohol-free, after-prom activities, in additional to educational presentations at pre-prom activities.
- **Stakeholders Group** – Banner Desert staff involvement and sponsor
- **Safe Kids Day** – Torrington Community Hospital partnered with Kiwanis and provided volunteers
- **SAFEKIDS Program** – Coalition to reduce preventable injuries and death in children ages 14 and under. FMH sponsors free car safety checks to community residents to ensure proper installation in vehicles and educate parents, participates in the Kids Don't Float water safety program, educates on fire prevention in conjunction with the fire department, educates on pedestrian safety with local schools, and works with schools to encourage the use of helmets, sponsors bike rodeos, and safe biking activities as part of the Safe Spoke'n program.
- **SAFEKIDS of Maricopa County** – Banner Desert staff involvement and sponsor.
- **SAFEKIDS of Sandhills** – Ogallala Community Hospital staff involvement and sponsor.
- **Safe Sitter Classes**
- **School Nurse Education (Banner Desert Children's Center)** – Provided full-day seminar for East Valley school nurses to assist them with medical issues encountered in their schools.
- **School Nurse Program (Banner Mesa)** – Worked in cooperation with Mesa and Apache Junction School Districts to provide nurse practitioners and other care to children with no access to healthcare.
- **School Supply Drive** - Provided area students with general school supplies along with backpacks and socks for each child (Ogallala Community Hospital)
- **Supporter of local sports activities** to encourage wellness and health from an early age (soccer, curling, football, basketball, hockey) (FMH)
- **Toys for Tots** – Employee donations
- **UAF Summer Research Academy** – sponsor (FMH)
- **Weld County, Colorado high schools** – NCMC sponsor of after-prom alternative events for students
- **Young Life** – Youth camp sponsor (FMH)

Banner does not keep a consolidated record of the cost of the staff time devoted to these activities, which constitutes by far the largest component of the support given by Banner, nor does Banner have a method for consistently or precisely tracking the other incidental expenses for these activities. Accordingly, it is not possible to provide an accurate number for the amount committed by Banner to the support of these community benefit programs.

21. Please explain how the amount of charity care you provide differs in magnitude and kind from that provided by your for-profit competitors?

Response: Banner does not have the information available to it to provide a meaningful comparison with for-profit hospitals operating in the areas served by Banner.

22. How much does your hospital spend on free or below-cost infant and child care programs, such as childhood immunization programs?

Response: As noted above, Banner engages in numerous programs for infants and children; however, Banner does not track its community benefit expenditures on this basis.

23. Does your organization conduct clinical trial programs, and if so, how does your organization treat such programs for purposes of determining charity care?

Response: As stated in Response A-15, Banner does conduct clinical trial programs. However, under the definition of charity care referenced in Response A.1, Banner's participation in clinical trial programs is not included in any determination of the amount of charity care provided by Banner.

24. How do you allocate expenses (direct labor and materials, indirect labor and materials, management, general and administrative, fund-raising, investment, and other) for purposes of determining the amounts you consider to have been expended on your charity care programs? Does this allocation include costs incurred pursuant to a cost-sharing arrangement with other members of your hospital system group? Is this allocation mechanism dictated by internal policy, Federal or State regulatory requirements, financial accounting principles, or other standards? Is your allocation of expenses to charity care consistent with expense allocation procedures your use to allocate expenses for other purposes, regulatory or otherwise? Please explain any similarities or differences.

Response: Allocations supporting the amounts that Banner reports as the cost of charity care include allocations for many, but not all, of the items set forth in the question. Our internal cost allocation methodologies rely on allocating costs on an average basis to the elements of care that are charged to patients, e.g. lab tests, supply items used, a day in an inpatient bed, etc. Each of these elements of care ("intermediate products" in cost accounting terminology) is assigned an average or "standard" cost and, as they are used by or provided to groups of patients, the costs are accumulated to arrive at a cost estimate for that group.

These cost estimates are imprecise on a patient-by-patient basis as a result of the many shortcuts and averages used for the allocations as well as the significant "bundling", or grouping, of similar intermediate products that is necessarily built into the cost accounting methodology. In short, the only number that is reportable with any degree of certainty are the total costs to care for all patients; any costs for subset(s) of all patients are estimates whose precision declines as the subset gets smaller. This is clearly the case for the reported cost of Banner's charity care; it is simply our best estimate. It is also worth noting that these estimates are highly sensitive to changes in allocation methodology, e.g., one arrives at a vastly different cost estimate if indirect overhead costs are allocated equally to all patients versus allocating them on the basis of the length of

stay for each patient even though both are supportable methods of cost allocation. The following list of the components of our cost, in declining order of magnitude, provides a brief description of the most prevalent method currently used to allocate each cost type to the variety of intermediate products:

a) Direct Labor. Direct labor is defined as labor cost within each clinical department. Banner maintains an accounting of the costs of each department. Labor is assigned to each intermediate product produced (tests, bed days, radiology image, therapy unit, etc) on the basis of relative value units assigned to each, reflecting the differential in labor input required by the variety of products produced by each clinical department.
b) Supplies and Materials. Supply and material costs are allocated to intermediate products on a direct basis when applicable (many supply items are themselves intermediate products) or by becoming part of the supply chain overhead costs and being allocated to the supply items which are intermediate products. These allocations are generally made on the basis of the relative values of the supply item costs.
c) Indirect labor and materials. All other costs, including management and administration, are considered indirect costs. These costs are generally allocated to the clinical departments noted above (and thus to their intermediate products) on the basis of a "step down" allocation that allocates or "steps down" the indirect costs for each overhead department in a pre-determined order to the receiving department in each hospital. These allocations are made using the best allocation method available, including statistics and accumulated costs.

   It should be noted that these "step down's" are performed within the cost structure of each Banner hospital. As a system of many hospitals and for reasons of enhancing efficiency, internal control, and customer service, Banner has centralized many business and administrative functions. The cost allocations for these services (accounting, planning, legal, information technology, etc) are made using allocation bases appropriate to that particular function and are not allocated in a "step down" fashion.

d) Fund-raising and investment costs. Since the question specifically highlighted the treatment of these cost elements, we will address both. The bulk of Banner's cost of raising donated funds, and virtually all of its direct costs of doing so, is accounted for separately from hospital costs and, as a result, does not enter into the cost allocated to our patients. With regard to investment costs, the bulk of these are accounted for as reductions to our investment earnings (earnings are net of fees) for purposes of financial and cost reporting. The costs of Banner's small staff (3 FTE's) who maintain oversight of treasury functions is included in our indirect labor costs (see centralized services reference above) and, as such, is part of our reported cost of charity care.

Except for the centralized costs noted above, the allocation of costs to our patients does not include costs incurred by other hospitals within the Banner system.

Our allocation method is not dictated by any statute or regulation. It is the result of study and research, consultation with other healthcare professionals and healthcare systems, and the application of general principles of cost accounting to each particular element of cost. The overriding objective of our cost allocation efforts is to provide meaningful information on the operating performance of service lines, payors and hospitals.

The allocation of cost to the services we provide patients on a charity basis is consistent in all respects with the method used to allocate expenses for other purposes with the single exception of the cost allocation utilized by the Medicare and most Medicaid programs, which are imposed by regulation.

25. Please provide a statistical breakdown of the hospital's average cost per patient and the average length of stay of your patients. Feel free to provide as much detail as you consider to be appropriate to demonstrate the range of costs and stays across different types of treatment.

Response: Using 2004 activity, Banner's average cost of treating an inpatient was $6,790 for each hospital stay and the average length of stay was 4 days. Considerable variation exists around these averages, however, with some service lines having cost/case as low as $2,377 and as high as $79,506. Length of stay varies in similar fashion from 2.74 days to slightly over 21 days. The table below summarizes this information and highlights the general economic model hospitals operate under, e.g., provide a full range of services required by the community and use some profitable ones to subsidize the others that are unprofitable. We note that 2004 results indicate losses in behavioral services, cardiology and vascular services, neonatal services (despite having low length of stay and cost per case), and rehabilitative services. Within these numbers, there are payer categories which are profitable despite overall losses in a specific service line. An example would be cardiology and vascular services, which are unprofitable in the aggregate where Banner is unable to control the patient, type of service, and payor selection, but are profitable for other payors and for particular types of patients and payors. We also note that there are payor categories that are also consistently unprofitable. Two of the most significant are obstetrical services to Medicaid patients which, in 2004, resulted in an average loss per case of $612 for each of the 14,369 cases treated at a Banner hospital, and cardiology services to Medicaid patients which resulted in a $2,979 loss for each of the 2,726 cases for the same period.

Service Line	Total Cases	Net Revenue	Estimated Total Cost	Avg Profit (Loss) per Case	Length Of Stay	Average Cost / Case
BEHAVIORAL	11,520	42,688,316	47,891,359	(452)	6.30	4,157
CARDIOVASCULAR	30,917	347,580,002	355,861,173	(268)	3.96	11,510
GEN MEDICINE	27,825	146,562,532	132,447,792	507	3.58	4,760
GEN SURGERY	14,161	181,883,477	157,210,540	1,742	5.82	11,102
INTENSIVE PROC	745	60,069,132	59,231,743	1,124	21.01	79,506
NEONATAL	28,740	61,441,228	68,304,374	(239)	2.74	2,377
NEUROLOGICAL	10,726	89,255,308	85,639,458	337	3.84	7,984
OB/GYN	37,976	162,602,921	156,518,016	160	2.81	4,121
ONCOLOGY	5,451	60,917,053	42,439,454	3,390	5.66	7,786
ORTHOPEDICS	11,220	116,715,023	113,682,194	270	4.10	10,132
REHABILITATION	1,661	21,986,552	22,727,516	(446)	13.04	13,683
RESPIRATORY	13,084	90,382,864	83,209,650	548	4.40	6,360
UROLOGICAL	7,143	43,793,020	40,890,548	406	3.92	5,725
UNCODED	6	2,960	11,005	(1,341)	1.67	1,834
Grand Total	201,175	1,425,880,388	1,366,064,822	297	4.00	6,790

B. PAYMENTS/CHARGES/DEBT COLLECTION/TAX-EXEMPT STATUS AND OTHER ISSUES

1. Please explain what is the average mark-up of charges over costs? What is the average private pay contractual allowance (charges to payments) weighted by payer?

Response: Implicit in this question is the notion that the purpose of a chargemaster is to establish a fixed relationship between charges and costs. This misstates the fundamental purpose of the chargemaster, which is to set the framework for the overall pricing structure of a hospital, not to establish a fixed relationship between charges In any event, the question is vague and does not address, for example, exactly what "costs" are to be included in the calculation. One type of calculation for determining the relationship between the charges set forth in the chargemaster and the costs incurred by Banner in providing services would be to do a simple comparison of total gross patient revenue against total costs. Using 2004 audited amounts, Banner's gross patient revenue was $6,758,190,000 and total expenses (costs) were $2,428,757,000, translating into an average ratio of 2.78.

The average "private pay contractual allowance", which we interpret to mean the percentage of charges written off to account for the difference between Banner's usual and customary charges, and negotiated rates with payers, for the same period and for our hospital volumes only, is 61%. This amount is "weighted by payer" (which we interpret to mean computing the average giving each payer a weighting that, on average, reflects its relative share of the volume). The "private pay contractual allowance", weighted by payor, is not readily available for our non-hospital services due to the disparate contracting and billing systems employed in these service lines.

2. Please explain the reason for charging "chargemaster" rates to uninsured individuals particularly in light of the Secretary of Health and Human Services' letter of February 19, 2004 to the President of the American Hospital Association and also in light of your not-for-profit and tax-exempt status.

Response: This question also overlooks the basic purpose of the chargemaster, which is to establish the basic pricing structure for the hospital which serves as the common denominator for pricing purposes. This question also appears to assume that there exists a federal or state statute, regulation or guidance that prescribes or limits the charges that an exempt nonprofit hospital may charge to persons who do not have health insurance, including persons who may choose not to purchase health insurance despite having the means to do so. Banner is unaware of any such authority and does not believe that any such authority exists. As noted above, Banner has a generous charity care policy that makes available care in Banner's hospital facilities for persons earning up to 500% of the federal poverty level at substantial discounts, and makes care available to persons having household incomes of $125,000 or less at rates that are generally comparable to those paid by commercial payors to Banner.

Prior to the letter referenced in the question, however, it was commonly believed by many health care lawyers and financial experts that the ability to provide an across-the-board discount from the usual and customary charges (i.e., the so-called "chargemaster" charges) was restricted by the widespread belief (now disclaimed) that Medicare required a uniform charge structure, the requirement that Medicare not be charged more than other payors (including self-pay patients), and the impact on providing unilateral discounts to self-pay patients upon the level of outlier reimbursement restricted the ability of hospitals to charge individuals something other than the charges set forth in the chargemaster. In particular, it was believed that if a hospital uniformly or frequently billed or accepted as payment in full from self-pay patients, except in cases of documented indigence, amounts that are discounted from the charges reported on Medicare outlier claims, the hospital would be leaving itself open to CMS contending that the charges on the outlier claim were fraudulent because they were not the hospital's "real" charges (with the assumption being that the "real" charges were the "chargemaster" charges). The same concern was expressed with respect to private payors whose payments were based upon charges. See, e.g., Dennis Barry, Medicare Update, (presentation made to American Health Lawyers Association, Annual Meeting, June 30, July 2, 2003), at 8. Indeed, it should be noted that the initial Q&A issued by CMS on February 20, 2004 immediately following the letter referenced above only addressed the question of whether waivers and discounts based on financial need would not affect Medicare payment, not many of the other questions that had been raised. Even as late as June, 2004, CMS staff still felt the necessity for clarifying for the hospital industry the key components involved in providing discounts to the uninsured and underinsured, and to confirm that a policy of discounting for uninsured would not create fraudulent outlier claims or other Medicare reimbursement problems. See, E-Mail Invitation to Special Open Door Forum: Billing Practices for the Uninsured and Underinsured, June 1, 2004, 11:00 am EDT, issued by CMS on May 24, 2004. Even during this Open Door Forum, representatives of CMS were emphasizing primarily that hospitals should have discount policies for medical indigents (rather than all persons

without health insurance, irrespective of income), and spelled out the general criteria that such a policy should consider. Only in response to specific questioning did the CMS representatives acknowledge that discounts could be provided to non-indigent patients, offering the guidance that such discounts should be categorized as "courtesy allowances".

Even apart from the Medicare considerations, Banner has a number of contracts with commercial payors that are based upon a percentage of Banner's usual and customary charges. Although we are working towards a more precise definition of these charges as we renew or replace such contracts, there is a substantial concern that if no residual class of patients is required to pay the usual and customary charges as set forth in our chargemasters, Banner would be potentially exposed to claims of fraud or to unintended reductions in expected reimbursement under such contracts.

3. Please explain how fairness or reasonableness of charges to the uninsured can be assured even in instances where you offer discounts where those discounts are discounts from the already high chargemaster rate? What is your discount policy? What is the collection rate for self-pay?

Response: Because this question overlaps with Questions B.4 and B.5, Questions B.3, B.4 and B.5 are answered together below in Response B.5.

4. If government programs pay for hospital services for its enrollees without regard to the chargemaster rate and commercial insurance carrier throughout the country likewise pay not based on the chargemaster rate, please explain why the uninsured continue to be charged the chargemaster rate?

Response: Because this question overlaps with Questions B.3 and B.5, Questions B.3, B.4 and B.5 are answered together below in Response B.5.

5. Please explain what is the economic benefit to your hospital of charging uninsureds the high chargemaster rate when uninsured people generally have less of an ability to pay hospital charges and do in fact generally pay only a fraction of what has been charged? Does this benefit justify your action particularly in light of your not-for-profit tax-exempt status?

Response: Please see Response A.1 for an accurate description of Banner's policies with respect to providing hospital services to lower income uninsured at no charge or reduced charge. As noted in Responses B.1 and B.2 above, the "high" chargemaster charges are in fact the common denominator for our hospitals' pricing structure, and many contracts with commercial payors are based upon discounts from the chargemaster charges. None of those commercial payor contracts provides for discounts as great as the discounts provided to lower income uninsured persons under Banner's charity care policies.

These are largely rhetorical questions that assume that the price to all those who could afford insurance but elect not to purchase insurance should be the same as the price to

those who do purchase insurance or are covered by government reimbursement programs. Further, the question (a) ignores the fact that many of Banner's commercial insurance payors also reimburse Banner on the basis of percentages of the chargemaster rates, (b) fails to distinguish between different categories of uninsured persons, (c) does not acknowledge the large number of uninsured patients who do not make any payments (or who make only modest payments) on their hospital bills, (d) does not recognize the historical development of hospital billing, which is based on the chargemaster system, and (e) incorrectly states that the chargemaster is irrelevant to government reimbursement because , as Question B.9 below recognizes, charges are a necessary component for determining Medicare and AHCCCS/Medicaid outlier reimbursement.

Banner believes that its policy of offering its hospital services at rates comparable to those paid by commercial payors to persons who have annual household incomes of less than $125,000 draws a reasonable distinction among categories of uninsured, including those who could afford insurance but choose not to purchase it.

The collection rate, expressed as a percentage of charges, from uninsured patients was 9.69% in 2003, and 12.65% in 2004, and a significant number of uninsured patients do not make any payments at all on their bills.

These questions also do not accurately describe Banner's motivation in setting prices to the uninsured or to the insured. Given that net revenue collected from self-pay accounts accounted for 0.58% of Banner's revenue in 2003, and 0.91% of Banner's revenue in 2004, it should be evident that Banner is not setting prices to the uninsured on the basis that there would be an "economic benefit" to Banner.

6. The Committee has heard statements from individuals that have gone to many not-for-profit tax-exempt hospitals in the very recent past and have seen no evidence of the fact that they make their tax-exempt and charitable missions known to patients via signs in patient access areas, brochures, booklets and the like. Please comment on what your hospital does to provide such visible information on the subject.

Response: We are uncertain as to what the Committee means when it refers to making Banner's tax-exempt and charitable mission "known" to patients in our facilities. Banner's corporate mission is as follows: "We exist to make a difference in people's lives through excellent patient care." This mission is displayed prominently in various public areas in Banner facilities, and is communicated frequently in Banner's brochures, media advertising, and through other public communication. With respect to Banner's community benefit, we make this known publicly through our annual Form 990, which is a matter of public record as required by IRS regulation, and through various public communications. This information is generally not communicated specifically to patients upon entering the hospital as patients rarely, if ever, inquire as to this information upon entry into our facilities.

Banner does, however, advise patients of our financial assistance and charity care policies through a variety of methods, focusing primarily at the points at which self-pay patients

most often enter into our hospitals (generally emergency department registration areas), and with the billing statements that are thereafter sent to patients. In Banner's Arizona facilities, posters in English and Spanish are displayed in all emergency departments waiting areas stating that financial assistance is available and providing an 800 number for patients to call. Registration personnel will, upon determining that a patient is uninsured, refer the patient to a financial counselor who offers information in accordance with a script (to ensure that none of the important components of the presentation are overlooked) regarding Banner's financial assistance programs as well as information on applying for AHCCCS assistance. Included with the initial statements to self-pay patients are colorful inserts stating that financial assistance is available to qualified persons, and providing an 800 number for the patients to call. Similar posters, brochures, billing inserts and procedures are in place in Banner's non-Arizona hospitals. A sampling of the posters and brochures used in Banner facilities to make patients aware of their financial options is included with this response.

7. Please identify what steps your hospital has taken to insure that lower level staff, who are actually the front-line staff, are aware of your not-for-profit status and charitable mission and have been instructed to implement the same in their treatment of uninsured patients. Please produce any documents conveying such information to your staff.

Response: Banner's staff members are expected to treat all patients in the same compassionate, caring, competent and professional manner, irrespective of whether they are insured. Indeed, most Banner clinical staff members are unaware of a patient's financial status. As noted above, Banner's registration and patient financial accounting personnel are trained in Banner's financial assistance policies and the procedures for implementing those policies for patients who indicate an interest in such assistance pursuant to the advertising in the facilities, the inquiries of financial counselors during the registration process, and the inserts included in initial billing statements. Banner does not provide specific instruction to its staff as to Banner's nonprofit status and charitable mission, although Banner is confident that its nonprofit status is well-known to its staff.

8. If your hospital believes that Medicare rules created roadblocks to providing discounts to the uninsured, as is evidenced by the president of the American Hospital Association's (AHA) December 2003 letter to the Department of Health and Human Services, why did your hospital, or your hospital through the AHA not raise the same with the Department at an earlier date? In considering this question it is noteworthy that in December of 2002, Trevor Fetter, the CEO of Tenet Healthcare, stated in an investor conference call "I would like to turn to an issue that has bothered me for years. I mentioned earlier that Medicare requires hospitals to set charges the same for everyone. This means that the uninsured or underinsured patient receives a bill of gross charges. In other words, the entire hospital industry renders its highest bills to the customers who are least able or likely to pay."

In addition, please state whether your organization ever grossed up their charges on the Medicare cost report because they had a lower OPD fee schedule? Please state your

views on whether it is allowable or acceptable for hospitals to lower their charges for the insured and not the uninsured.

Response: These questions are argumentative and incorporate a number of unstated assumptions that may not be accurate. Banner has traditionally not been active in national advocacy activities involving CMS or the Department of Health and Human Services. Banner did, some years ago, gross up charges in the surgery area to account for its lower ambulatory surgery rates. This occurred several years ago, and it was not possible to investigate the details within the deadline established for this response.

As a number of federal and state courts have recently held, in dismissing cased filed as part of the current wave of putative class actions filed against nonprofit hospitals alleging claims that appear to be remarkably similar to the claims/assumptions inferred in many of the Committee's questions, there is no law that prohibits hospitals from negotiating rates with commercial health insurance payors that are lower than (or tied in any manner to) the rates charged to self-pay patients. See, e.g., *Kolari v. New York Presbyterian Hospital*, 2005 WL 710452 (S.D.N.Y. Mar. 29, 2005); *Bobo v. Christus Health*, 2005 WL 1034133 (E.D.Tex. Apr. 26, 2005).; *Pitts v. Phoebe Putney Health System, Inc.*, Dougherty County, Georgia, Superior Court, 04CV1991-3, Order Granting Motion to Dismiss, June 27, 2005; *Shelton v. Duke University Health System, Inc.*, Wake County, N.C. Superior Court, 05-CVS-001985, Memorandum Order Allowing Defendant's Motion to Dismiss, July 11, 2005. These courts likewise have confirmed that nonprofit tax status does not depend on the prices charged to any particular payor class, and that there are numerous means by which a nonprofit hospital can meet its obligations under Section 501(c)(3).

9. It has been suggested that one of the reasons that a hospital may have maintained these high chargemaster rates is that it allows the hospital to obtain more in the way of Medicare outlier payments thus further costing the government additional money for the care of the uninsured. Please explain why your hospital, as a tax-exempt not-for-profit hospital, feels that this is appropriate or inappropriate. What was the growth rate in your Medicare outlier payments from 1998 to 2002?

Response: The relationship of charges to Medicare outlier payments is irrelevant to a hospital's tax status. Charges are important in calculating outlier reimbursement as a statistic to arrive at cost. The outlier reimbursement is based upon the application of a hospital's cost-to-charge ratio as applied to the charges. If changes in charges are manipulated to outpace adjustments in the cost-to-charge ratio, then the charges can operate to increase reimbursement in excess of the expected reimbursement.

In any event, the amount of Medicare outlier payments received by Banner *declined* by 22.1% from 1998 to 2002; expressed as a percentage of the DRG/capital reimbursement payments received by Banner from 1998 to 2002, the outlier payments *declined* by 38.5%.

10. Secretary Thompson, in his letter mentioned above, noted that "Medicare and Medicaid have a long history of doing their part to help the uninsured that includes paying hospitals $22 billion each year through the disproportionate share hospitals' provision to help hospitals bear the cost of caring for the poor and uninsured." In light of the fact that you are a tax-exempt not-for-profit hospital, please comment on whether or not you believe it is appropriate for your hospital to receive such aid from the government. Please list your payments under disproportionate share for the past three years as compared to uncompenstated [sic] care, separating out bad debt.

Response: Banner believes that disproportionate share payments are a critical component of financial support to assist all hospitals, nonprofit and for-profit, in dealing with the substantial portion of our county's population that is not insured, and for complying with federal mandates requiring the provision of emergency medical screening and stabilization without regard to ability to pay. This is especially true in some of the states served by Banner, such as Arizona, which have below-average per capita incomes, large numbers of uninsured individuals, and large populations of undocumented persons. We note also that disproportionate share payments are determined based upon certain categories of patients covered by Medicaid, not just the number of uninsured patients.

The following table sets forth the disproportionate share payments, charity care and bad debt received, provided or incurred by Banner during 2002, 2003 and 2004.

Year	Disproportionate Share Payments (Medicare and Medicaid)	Charity Care	Bad Debt
2002	$21,678,701	$53,511,499	$134,628,606
2003	27,895,116	52,140,939	145,912,802
2004	35,542,700	48,269,761	212,830,299

11. Do you agree that the chargemaster method of charging uninsureds should be discontinued? In answering, I would ask that you consider the statement of Mr. Jack Bovender, the Chairman and CEO of Hospitals Corporation of America, one of the largest for-profit hospitals in the country. Mr. Bovender has stated, "the chargemaster system on which hospitals rely to set pricing and billing codes have a 40 year history of changes that have distorted the relationship between price and cost. It grew out of a time when decreasing Medicare reimbursement prompted cost shifting to the private sector and this was exacerbated in the 90's by aggressive managed care discounting. I am not here to try to justify this and it really needs to be fixed."

Response: Banner notes that the portion of Mr. Bovender's comment relating to the long history of the chargemaster system is consistent with Banner's statements above that the roots of the chargemaster system have nothing whatsoever to do with motivation for

pricing to the uninsured. However, the question is ambiguous as to whether the Committee is inquiring as to whether usual and customary charges, as set forth in the chargemaster, should be used as a basis for determining the amount to charge uninsureds, whether in the full amount or as a percentage thereof, or whether the Committee is questioning whether the full amount of the usual and customary charges should be charged to the uninsured. As to the application of the chargemaster as noted above, Banner has a number of negotiated commercial payor contracts under which Banner is compensated on the basis of a percentage of the "chargemaster" charges. This would suggest that the relationship between Banner's charges and costs is not as distorted as the quote would indicate.

As noted in Response A.1, Banner has moved away from its usual and customary charges to a percentage of expected Medicare DRG reimbursement in determining the amount to be paid by patients qualifying for Banner's financial assistance programs, including persons having household incomes of $125,000 or less. While it was Banner's desire to utilize Medicare prospective payment amounts as the basis for outpatient as well as inpatient, discounts, the outpatient methodology used by Medicare is so complicated that it cannot be modeled within Banner's current billing systems. Accordingly, Banner will continue to base its financial assistance programs for outpatient services on a percentage of its "chargemaster" charges.

12. At the hearing of the Oversight Investigation Subcommittee of the House Energy and Commerce Committee on hospital billing dated June 24, 2004, Mr. Bovender stated that he "was told by both inside and outside legal counsel...[in late 2002] that we had to get clearance [for discounting to the uninsured] through CMS." Please identify whether your hospital has received such legal advice and if so, please provide any written documentation of that advice.

Response: To the extent that this question calls for waiver of the attorney-client privilege, Banner respectfully declines to respond to this question. However, many in the health care legal and financial professional communities believed until 2004 that discounting for uninsured patients without examining making a determination of financial need was disapproved by Medicare. See Response No. B.2. This position was not definitively repudiated by CMS until June 2004, and even then CMS had to issue special instructions on how to record discounts given without regard to financial need on Medicare cost reports.

13. Please provide all documents related to your hospital's consideration of medical charges for billing practices, charity or indigent care, discounts or write-offs to uninsured patients.

Response: We will provide our policies for financial assistance to insured and underinsured persons, as well as our policies for prompt payment discounts and installment payments, our financial assistance application forms, and examples of the various brochures and posters used to inform patients of the opportunity to apply for financial assistance. These documents are enclosed.

14. Please provide all documents relating to your charity care policy, community benefit reports, community benefit assessment, community benefit strategy and/or charity care audits for the time period of January 1, 1998 through the present. In providing the same, please identify specifically where those documents consider your hospital's treatment of the uninsured.

Response: We will provide the charity care policies in effect for Banner from 1999 and Part III of our Form 990's from 1998 through 2003, describing the community benefit provided by Banner. We will also provide copies of annual reports for Lutheran Health Systems/Banner for 1998, 1999 and 2000 (these reports were discontinued thereafter). Except in summary disclosure of the aggregate community benefit and charity care, the annual reports and Form 990's do not specifically address care provided to the uninsured.

15. Please provide any community needs assessment done by you or on your behalf during the time period of January 1, 1998 through the present. In providing the same, please identify specifically where your hospital considered its treatment of the uninsured in its community needs assessment.

Response: Banner does not have any community needs assessments responsive to the Committee's request.

16. Please identify how many lawsuits you have filed against uninsured patients for the current year and the preceding five calendar years and please identify whether or not you are compelled by law to file such lawsuits in order to collect from these individuals. Please identify the amount of debt that was at issue in each suit. Please identify any times you have sold debt owed to the hospital from uninsured patients to other companies for collection. Please state the amount the debt(s) was sold for, and the terms under which such private collection accounts were sold. In particular, please estimate the volume and value of accounts sold to private companies in the past five years, and whether those sales were made after our hospital rigorously pursued the patient on its own, and whether or not the hospital also claimed those same accounts for purposes of collecting the 70% bad debt payments made available to hospitals that despite best efforts, fail to recover aged patient accounts. Please explain how the sale of private accounts for recover, and an [sic] concomitant claim to Medicare for payments on the same debts, is not "double dipping."

Please provide copies of your contracts, if any, with collection agencies. Please identify whether this collection agency is a for-profit or nonprofit subsidiary of your organization. Please discuss any financial relationship with a bank or credit card company that patients use to help finance their debt. Please explain if you differentiate between Medicare and Non-Medicare patients in regard to debt. If you sell debt, what is your policy on when that debt is sold, particularly in terms of the age of the debt.

Response: Banner does not believe that it is compelled by law to file claims against patients, except in Alaska, where a lawsuit is required by state law in order to garnish payments owed to patients by the Alaska Premenate Fund Dividend. Banner does not sell

debt to other companies for collection. Current contracts with collection agencies are enclosed with response. No collection agency is a subsidiary of Banner Health.

Banner is aware that Medicare requires us to use the same collection efforts in pursuing Medicare patients for co-payments and deductibles as we use for non-Medicare patients. Accordingly, Banner does not differentiate between Medicare and non-Medicare debt.

Banner has an agreement in Fairbanks, Alaska with Northrim Bank pursuant to which patients may apply to the bank for loans up to $25,000 to fund payment of their accounts, and Banner guarantees payment of bank's loan to the patient. Patients are required to fill out a loan application, which is then subject to acceptance by the bank. The maximum term of the loans is five years, and the interest rate is based on the bank's "New Car Rate".

In 2004, Banner entered into an agreement with Medical Acquisition Corporation ("MAC") involving the potential sale of accounts receivable for services rendered to patients in Banner's burn unit at North Colorado Medical Center in circumstances where it appeared that a third party was at fault for the patient's burn injuries. If MAC elected to purchase the receivables, it would then be obligated to pay for the patient's care according to a fee schedule (and therefore such account would not be claimed as bad debt). However, no accounts have ever actually been sold, and this arrangement will be allowed to expire in accordance with its terms on July 14, 2005.

Banner has contracts with several collection agencies. Copies of these contracts are enclosed with this response.

It is not possible to determine precisely the number of lawsuits filed against uninsured persons because the databases of some of the collection agencies that file lawsuits on behalf of Banner are unable to distinguish lawsuits filed against uninsured individuals from lawsuits filed against individuals with insurance who have failed to pay on the portion of the bill that is the patient's responsibility, such as co-payments, co-insurance or deductibles. We have also been unable to obtain complete lawsuit information from the collection agency that Banner utilizes for its Fallon, Nevada facility. The following is the best information that we have been able to pull together within the timeframe allowed for this response. No lawsuits were filed in California during this period.

Arizona: Banner, or collection agencies acting in the name of Banner, has filed 11 lawsuits since 2000, and none since 2003. A schedule listing the patients who are the subject of these lawsuits and the amount of the claims is attached to this response.

Colorado, Wyoming, and Nebraska: Collection agencies acting in the name of Banner filed 8,744 lawsuits from January 1, 2000 until May 31, 2005. Schedules listing these lawsuits and the amounts at issue are attached to this response.

Alaska: Collection agencies acting in the name of Banner have filed lawsuits on 2,914 patient accounts from January 1, 2000 until May 31, 2005. Schedules listing these lawsuits and the amounts at issue are attached to this response.

17. Please identify any money or investments that your hospital or related organization (including supporting organization or private foundation) has in off-shore bank. Identify the amount in these accounts. Please explain why your organization has taken this action.

Response: Like many United States corporations, for-profit and nonprofit, Banner has established a wholly owned, captive insurance company, Samaritan Insurance Funding Ltd. ("SIFL"), domiciled in the Cayman Islands. This company provides the primary layers of self-insurance for Banner's general and professional liability coverage, as well as certain other insurance coverages. Funding levels for SIFL are determined based upon annual reports prepared by an independent actuarial firm. Use of SIFL provides a cost-effective and flexible method for Banner to finance its risk exposure. No Banner funds are "diverted" or somehow "sheltered" offshore through Banner's ownership and financial relationship with SIFL or otherwise.

SIFL has a call account at Bank of Butterfield. Banner deposits premiums into the account and SIFL pays administrative expenses and insurance losses from the account. SIFL maintains a balance of approximately $200,000 in the account. Excess funds are routinely transferred to Northern Trust, investment trustee for SIFL and Banner, and invested by Northern Trust. As of 6/30, the account has a balance of $205,572.

SIFL invests its cash with the fixed income manager, PIMCO. All transactions are handled between PIMCO and Northern Trust. From time to time, Northern Trust has excess funds that are un-invested, in transit for unsettled trades etc. Cash is generally held for short periods of time. Northern Trust utilizes an offshore omnibus account for these funds. SIFL funds are commingled with other Northern Trust clients in this account. As of June 28, Northern Trust reported total funds for SIFL in the omnibus account of $1,306,609.

18. Please provide an organization chart including Type I and Type II supporting organizations. The chart should identify ownership interest and the type of organization (nonprofit, for profit, partnership, etc.).

Response: An organization chart is enclosed with this Response.

19. Some hospitals have taken the position that the provision of healthcare, no matter the cost to the patient, is inherently charitable. Do you agree that the provision of health care to uninsureds is charitable even if there is a high charge associated with it? If so, please explain.

Response: Banner does not have a position on the proposition advanced in the question. The IRS has identified the promotion of health as one of the purposes of the general law of charity that is deemed beneficial to the community, and therefore an activity that meets the community benefit standard for tax exemption. Rev. Rul. 69-545. Courts have repeatedly recognized that there is no fixed definition of the community benefit standard in the hospital context, and have recognized that something more than merely providing healthcare services is required for exemption. The IRS has identified, as examples, providing free or below-cost services, maintaining an emergency room open to all, regardless of ability to pay; and devoting surpluses to research, education and medical training. Rev. Rul. 83-157 further noted that, even in the absence of an emergency room, a hospital could qualify for exemption based on the totality of circumstances, including a board of directors drawn from the community, an open medical staff policy, treatment of persons paying their bills with the aid of public programs like Medicare and Medicaid, and the application of any surplus to improving facilities, equipment, patient care, and medical training, education and research. See also, *IHC Health Plans, Inc. v. Comm.*, 325 F.3d 1188, 1197 (10th Cir. 2003).

Banner believes that it qualifies for exemption under the current IRS standards. We note, again, that we recently completed a comprehensive audit by the IRS, and that no issues were raised with respect to our continued qualification as an exempt organization under Section 501(c)(3).

20. Some hospitals have stated that all patients, insured and uninsured alike, are charged the same amount for services. It seems that this is a response based on semantics as it is my understanding that all insureds and governmental payors ultimately are expected to pay less than the chargemaster rate while uninsured patients are expected to pay the full amount. Please respond and in your response identify the net effective discount to all patient groups based on contractual or other allowances with those groups and identify the discount offered to uninsured patients as well. Please explain what your policies are for providing elective procedures, ex. breast biopsies, mammograms, colonoscopies, physicals, etc. to the uninsured.

Response: See Responses A.1, B.1 and B.5. Except for physicals, the other procedures are, if medically necessary, not considered by Banner to be "elective" and are therefore covered by Banner's financial assistance program. However, these procedures in most cases also require a physician to perform such services. The overwhelming majority of the physicians who practice in Banner hospitals are not employed by Banner, and patients seeking to obtain such services except via hospital Emergency Departments must first identify a private physician willing to perform the service. Many, if not most, financially needy uninsured persons do not have private physicians available to them who are willing to perform such services without compensation. For this reason, most uninsured persons access Banner hospital services through the Emergency Departments where, as noted above in Responses A.1 and A.18, such individuals have access to emergency department physicians and to specialty physicians as needed.

21. Please provide for the last three years a detailed breakdown of travel of your five top salaried employees: for trips over $1000 please provide receipts for hotel; meals; airfare and all other reimbursed items as well as the purpose of the trip. Please provide all salaries and other benefits provided to these five individuals for the last three years from any organization identified in question B18. Finally, please detail any payments or reimbursements made to employees for country clubs.

Response: Attached to this response are summaries of the travel reimbursements paid to the top five salaried Banner employees in 2002, 2003 and 2004. One of the top five employees in 2002 was receiving severance payments, and therefore did not receive any travel reimbursement. Also enclosed with this response are copies of the expense reports, with copies of receipts, for trips involving reimbursement over $1,000. We have been unable to locate expense reports for a small number of the reimbursed trips taken in 2002, and have been unable to determine travel reimbursement or locate expense reports for travel taken by Mr. Craig Broman in 2002, during which he left employment by Banner. We believe that these records were misplaced during the consolidation of Banner's corporate headquarters from Fargo (where Mr. Broman was based) to Phoenix. Please note that in many instances the destination and hotel for which reimbursement was paid was determined by the location of the conference or business event attended by the Banner executive.

Attached to this response are summaries of the salaries and other benefits provided to the top five salaried employees for 2002, 2003 and 2004. None of the top five salaried Banner employees received salaries or other benefits from any other entity identified in Question B.18. Please note that the payments reported to Steven Orr in 2002 represented payment of deferred compensation (previously reported as such on prior years' Forms 990) and severance payments. These payments were specifically examined by the IRS in the recently completed comprehensive audit, and no excess benefit or other excise tax or intermediate sanction was assessed.

Also attached to this response are reimbursements made to employees for country club memberships. We are excluding reimbursements made to employees who incurred out-of-pocket expenses for meetings and other business functions which were held at country clubs instead of local hotels, restaurants or conference centers. The only two employees who received reimbursements for country club memberships were the President/Chief Executive Officer of Banner, and the President of the Banner Health Foundation. The country club membership reimbursement benefit for the President/Chief Executive Officer of Banner was discontinued in 2003.

ATTACHMENTS TO RESPONSES OF BANNER HEALTH TO MAY 25, 2005 LETTER FROM SENATE FINANCE COMMITTEE

1. Current Financial Assistance Policies.
   a) Financial Assistance for Uninsured Patients
   b) Financial Assistance for Insured Patients
   c) Installment Payment Arrangements
   d) Prompt Pay Discounts

2. Sample of Materials to Inform Patients of Available Financial Assistance

3. Financial Assistance Application Forms; Past Financial Assistance Policies
   a) Certification Required for Qualification for Basic Financial Assistance Program
   b) Arizona Enhanced Financial Assistance Application Materials
   c) Western Regional Financial Assistance Application Materials (including Colorado Indigent Care Program Application)
   d) Prior Financial Assistance Policies of Banner Health/Samaritan Health/Lutheran Health Systems

4. Annual Reports of Lutheran Health Systems/Banner Health for 1998-2000.

5. Part III of Forms 990 for Banner Health for 1998-2003

6. Lawsuits filed by Banner Health for Unpaid Uninsured Patient Accounts
   a) Arizona (all hospitals)
   b) East Morgan Community Hospital
   c) North Colorado Medical Center
   d) McKee Medical Center
   e) Sterling Regional MedCenter
   f) Washakie Memorial Hospital
   g) Platte County Memorial Hospital
   h) Community Hospital
   i) Ogallala Community Hospital
   j) Fairbanks Memorial Hospital

7. Contracts with Collection Agencies
   a) Consulting and Services Agreement, dated May 1, 2002, between Magnet Solutions, Inc. and Banner, dba Ogallala Community Hospital, as amended by First Amendment, dated May 1, 2005.
   b) Contract for Collection Services, dated February 2, 2002, between Washakie Medical Center and CollectionCenter, Inc./ICT, Inc., as amended by Addendum to Contract for Services, dated February 2, 2005.
   c) Contract for Collection Services, dated June 4, 2002, between Platte County Hospital and CollectionCenter, Inc./ICT, Inc.

d) Contract for Services, dated April 14, 2003, between Affiliated Credit Services, Inc. and Banner Health dba Sterling Regional MedCenter and East Morgan County Hospital.
e) Contract for Services, dated January 1, 2003, between Professional Finance Company, Inc. and Banner Health dba North Colorado Medical Center, McKee Medical Center, Platte County Memorial Hospital, Community Hospital, Washakie Memorial Hospital.
f) Agreement for Collection Services, dated June 26, 2002, between Fairbanks Memorial Hospital and Cornerstone Credit Services, LLC.
g) Agreement for Collection Services, dated October 5, 2004, between OSI Collection Service, Inc. and Fairbanks Memorial Hospital.
h) Services Agreement, dated January 1, 2004, between HealthCare Collections, L.L.C. and Banner Health, with related Business Associate Agreement.
i) Agreement, dated May 1, 1998, with Medical Society Business Services dba Bureau of Medical Economics, with related Business Associate Agreement.
j) Services Agreement, dated January 1, 2004, with Collection Service Bureau, Inc., with related Business Associate Agreement.

8. Organization Chart for Banner Health and Affiliates

9. Summary of Travel Reimbursement for Top Five Salaried Employees for 2002, 2003 and 2004.

10. Expense Reports for Top Five Salaried Employees for Travel Reimbursement for Trips in excess of $1,000/trip for 2002, 2003 and 2004.

11. Summaries of Salary and Other Benefits Paid to Top Five Salaried Employees in 2002, 2003 and 2004.

12. Summaries of Country Club Membership Reimbursement Paid to Banner Health Employees in 2002, 2003 and 2004.