REPORT OF THE ATTORNEY GENERAL,
DIRECTOR OF CHARITABLE TRUSTS

ON THE

PROPOSED INTEGRATION AGREEMENT BETWEEN
VALLEY REGIONAL HEALTHCARE, INC. AND
VALLEY REGIONAL HOSPITAL, INC.
AND
DARTMOUTH-HITCHCOCK HEALTH

April 1, 2024

I. Introduction

On December 16, 2022, pursuant to RSA 7:19-b, Valley Regional Healthcare, Inc. ("VRHC") and Valley Regional Hospital, Inc. ("VRH") submitted to the Charitable Trusts Unit of the New Hampshire Department of Justice ("CTU") notice of a proposed change of control transaction involving Dartmouth-Hitchcock Health ("DHH").[1] Under the terms of the Integration Agreement entered into between the parties and its subsequent amendments ("Agreement"), DHH will become the sole member of VRHC and will retain certain reserved powers over VRH and VRHC. This report describes the proposed transaction and the CTU's review and conclusions.

A. The Entities Involved

1. Valley Regional Healthcare, Inc.

VRHC was established as a New Hampshire nonprofit corporation in 1986. Its purposes as articulated in its amended articles of agreement are as follows:

(a) To support and benefit Valley Regional Hospital, Inc. or to perform some of the charitable functions of Valley Regional Hospital, Inc., including the actual operation and management of a hospital or hospitals, directly or indirectly, for the care of persons suffering from illnesses or disabilities, and to otherwise carry out the purposes of Valley Regional Hospital, Inc.
(b) To be the incorporator and owner of Valley Regional Hospital, Inc. and to elect and appoint the Board of Directors of Valley Regional Hospital, Inc.

[1] The Notice and exhibits are posted to the New Hampshire Department of Justice website.

See Affidavit of Amendment of Valley Regional Healthcare, Inc. (7/11/2016).[2]

2. Valley Regional Hospital, Inc.

VRH is a critical access hospital in Claremont, New Hampshire, formed by the Ladies Union Aid Society in 1893. Its purpose, as articulated in the amended and restated Articles of Association, is to, among other things, "establish and maintain a hospital for the care of persons suffering from illnesses or disabilities which require that the patients receive in- or out-patient hospital care." *See* Amended and Restated Articles of Association of VRH, as amended (3/28/2005).[3] VRH currently has 25 licensed beds (21 staffed beds) and 346 employees. VRH offers the following health care services: cardiology, pulmonology, oncology/hematology, general surgery, orthopedics, obstetrics/gynecology, rehabilitation services, occupational health, urgent care, and emergency care.

For a critical access hospital, VRH's emergency department experiences a high volume of patients with approximately 28 patient visits per day. This number does not include the patients who visit the onsite urgent care clinic that is open daily. Since VRH's labor and delivery unit closed in 2012, VRH's emergency department has helped to deliver approximately 4 babies per year.

VRH also has a very busy rehabilitation unit and, because of lack of space, has had to convert offices to therapy rooms. VRH has established one emergency psychiatric bed. VRH's surgical suite is modern but under-utilized. 95% of surgeries that take place at VRH are day surgeries, and only one of its three operating rooms is in use most days.

VRH underwent a major construction project in 2009. Among other changes, VRH relocated and updated the emergency department and created a new lobby area with private registration rooms. On the day of the CTU's visit to VRH in April 2023, VRH was preparing to begin a construction project to update its laboratory and radiology departments and its central sterile room. The cost of the project was projected to be approximately $5 million.

The VRH board has long recognized that its medical office space is inefficient and dated. The examination rooms are small and inadequate, and there are an insufficient number of offices for physicians. The hallways in one of the buildings that house examination rooms is so narrow that it would be difficult for a wheelchair to maneuver. Based on an interview conducted by the

[2] The Affidavit of Amendment of VRHC can be found on the NH Secretary of State's website.

[3] The Amended and Restated Articles of Association can be found on the NH Secretary of State's website.

CTU, in a 2019 presentation to the board, VRH's outside consultant referred to the medical office space as a "morale killer."[4]

The VRH board has developed plans for a new medical office building that would include examination rooms, office space, and additional space for physical therapy, occupational therapy, and other rehabilitation services. The building would be constructed across the street from the hospital at a cost of approximately $20 million. The VRH board has been able to set aside $14 million of unrestricted funds for the project.

VRH and DHH have had a long-standing clinical and contractual relationship. For example, DHH providers offer cardiology, oncology, pathology, and radiology services at VRH. In addition, DHH and VRH currently are parties to a management services agreement under which DHH provides to VRH a chief executive officer ("CEO") and chief medical officer ("CMO"). VRH is a member of DHH's New England Alliance for Health, LLC ("NEAH").[5]

VRH and Mt. Ascutney Hospital and Health Center in Windsor, Vermont ("MAHHC"), a DHH critical access hospital, share certain medical equipment and clinical and managerial staff.[6] An MRI truck spends some weekdays at VRH and others at MAHHC. Since 2021, the Director of Rehabilitation Services and the Lab Director for MAHHC serve in the same capacity at VRH.

3. Dartmouth-Hitchcock Health

DHH is the supporting organization for members of the Dartmouth-Hitchcock Health System.[7] The DHH System includes:

- New Hampshire's only academic medical center, Dartmouth-Hitchcock Medical Center;
- Mary Hitchcock Memorial Hospital ("MHMH") in Lebanon, New Hampshire with 396 beds;
- MAHHC in Windsor, Vermont with 25 beds;
- Alice Peck Day Memorial Hospital in Lebanon with 23 beds;
- New London Hospital in New London, New Hampshire with 25 beds);

[4] Wellesley Partners Presentation to the Board (2019) VRH 0000146.

[5] NEAH is a regional group of hospitals, behavioral health centers, and home health agencies established in 2008 to "provide services to enhance the quality and efficiency of health care and the promotion of collaboration, coordination of care, and population-based resources planning on a regional basis." NEAH's Certificate of Formation may be found on the NH Secretary of State's website.

[6] The driving distance between MAAHC and VRH is approximately 10 miles.

[7] On April 12, 2022, DHH announced a new name: Dartmouth Health. However, the name change is not yet reflected on the NH Secretary of State's website.

- Cheshire Medical Center in Keene, New Hampshire with 98 beds;
- Southwestern Vermont Medical Center in Bennington, VT with 99 beds;
- A visiting nurse and hospice association for Vermont and New Hampshire; and
- Medical clinics and practices throughout New Hampshire and Vermont.

DHH is New Hampshire's largest employer, with 13,000 employees, including over 2,000 clinical providers. DHH also is the largest provider of telehealth services in Northern New England.

DHH's Department of Psychiatry provides professional services at New Hampshire Hospital under a contract with the State of New Hampshire. MHMH hosts approximately 21 voluntary inpatient psychiatric beds. Neither MHMH nor any other DHH subsidiary offer beds for involuntary mental health patients.

B. Overview of the Terms of the Proposed Transaction

1. Authority of DHH as Sole Member of VRH

Under the terms of the Agreement, DHH will replace VRHC as the sole corporate member of VRH and will have substantial authority over the governance of VRH. For example, DHH will have final approval authority over the following:

- Nominees to the VRH board and the size of the VRH board;
- Operating and capital budgets;
- Strategic initiatives and plans;
- The incurrence of any unbudgeted indebtedness or other borrowings that exceed $500,000;
- Any unbudgeted proposal to sell, convey, lease, or grant a mortgage on assets in excess of $500,000;
- The decision to eliminate or add any health care services or programs, change any licenses, or otherwise change the "operating character" of VRH, "but only to the extent that such actions could have a material adverse impact on the finances of, or the delivery of care by, the Corporation or the [DHH] System;"[8]
- Closure, liquidation, dissolution of VRH or a change to the operating character or designation of VRH as a critical access hospital;
- Amendment of VRH's articles of agreement and bylaws;

[8] Draft bylaws, p. 4.

- VRH's exercise of its reserved powers over its affiliates; and
- Merger or change of control or acquisition.

In addition, DHH will have authority to initiate the following, among other, actions:

- Remove VRH trustees;
- Hire, evaluate, compensate, and terminate the president and CEO of VRH; and
- Initiate a change in the clinical services provided by VRH if necessary to implement the DHH strategic plan and DHH system-wide objectives or improve the financial position of VRH. In making such a decision, DHH must evaluate the impact of the proposed change on, among other things, the ability of VRH to meet the health needs of the communities in its service area, the availability to VRH to qualify as a critical access hospital, the quality and efficiency with which VRH can deliver health services, and VRH's charitable purpose. DHH will give VRH the opportunity to address the proposed change and provide additional information, and DHH will give good faith consideration to VRH's input.

2. VRH Board

The VRH board will direct the business and affairs of VRH, subject to DHH's reserved powers. The VRH board will consist of between 13 and 24 elected trustees, almost all of whom also serve as trustees of MAHHC. VRH's CEO (who is also MAHHC's CEO) and VRH's Medical Staff President will serve on the VRH board *ex officio* with voting rights. VRH and MAHHC each will nominate up to 7 trustees to both boards, subject to approval by DHH. In addition, DHH will appoint up to 1/3 of the VRH board, and the DHH CEO will be included in calculation of the 1/3 of appointees.

3. VRH Management

VRH and MAHHC will be jointly managed by a unified senior management team comprised of a CEO, a CMO, and a chief financial officer ("CFO"). With respect to VRH matters, the CEO will report jointly to the DHH CEO and the VRH board. VRH's other senior executives will report jointly to the CEO and DHH "Shared Services Leaders." VRH's senior executives will be invited and expected to attend DHH system senior executive meetings.

4. Integration into DHH System and Assessments by DHH

VRH will develop a strategic plan compatible with the DHH's strategic plan and, except with respect to implementation of information technology,

VRH will be expected to fund its implementation. VRH's financial management will be conducted in accordance with DHH's financial principles. Certain administrative functions of VRH may be consolidated with those of the DHH system or system members. VRH will be primarily responsible for preparing (in collaboration with DHH) a community services plan to serve as a guide for the development and expansion of services in VRH's service area. Clinical and other programmatic initiatives and development at VRH are subject to DHH approval. VRH will participate in DHH system-wide programs and initiatives, including group purchasing, IT system integration, quality improvement measures, and shared corporate services. DHH can assess a fee or other reasonable charge for such programs or initiatives.

After DHH develops a long-term strategic plan for achieving DHH system goals, VRH will develop a strategic plan consistent with the DHH system plan. VRH will fund its strategic plan implementation from its own operations and investment earnings. VRH will also participate in DHH system strategies, delivery networks, products, and other initiatives consistent with the DHH system strategic plan.

In any budget, DHH will have the authority to propose an allocation of VRH's operating margin for use within the DHH system. The proposal will be subject to approval by both the VRH board and DHH.

DHH will also have the authority to propose in each budget an assessment to cover VRH's share of the operating expenses of DHH and "reasonable contingency amounts for its activities."

5. Electronic Medical Records Integration

VRH and DHH will develop a plan for implementation of the EPIC electronic medical records system at VRH. Under the Agreement, DHH will pay 75% of the capital costs of the EPIC conversion, and VRH will pay 25% of the capital costs and 100% of the costs for local hardware and other connectivity expenses. DHH will charge VRH a fee for management and support of the EPIC platform.

6. VRH's Capital Projects

DHH did not make any capital project funding commitments under the Agreement. The sources of funding for capital projects at VRH will be through financing, operating revenues, and philanthropy. All capital projects at VRH, including the medical office building project, must be approved by both the VRH board and the DHH board.

7. VRH's Philanthropic Funds

VRH will have exclusive control of all donor-restricted gifts pledged, accumulated, or distributed to VRH. Unrestricted gifts made to VRH will be used for the benefit of the "Service Area," defined in the Agreement as Sullivan County, New Hampshire and Windsor County, Vermont. VRH will be expected to participate in DHH system fundraising, the proceeds of which will become DHH system assets.

8. DHH's Commitment to Fulfill VRH's Charitable Objects

Included with the Notice was DHH's statement regarding the manner in which it proposes to fulfill VRH's charitable objects. *See* Notice, Exhibit 9. Among the representations included in the document were a recognition that the development of a new medical office building at VRH is a key strategic priority to ensure the efficient and effective delivery of health care services at VRH. The document also includes a commitment to integrate VRH into the DHH system to "best address the needs of the residents of the communities throughout the service area." *Id*.

II. Review by the Charitable Trusts Unit

A. Overview

Under state law, RSA 7:19-b, the Director of Charitable Trusts of the Attorney General's Office is charged with reviewing acquisition transactions involving healthcare charitable trusts and determining compliance with the statute's provisions. In making this determination, the Director is required to accept public comment and may conduct public hearings. RSA 7:19-b, IV. RSA 7:19-b, IV requires that the Director of Charitable Trusts make his or her determination within a reasonable time not to exceed 180 days after receipt of a notice of a proposed acquisition transaction. In this case, the parties entered into eight tolling agreements to extend the deadline for a report to April 1, 2024.

After receiving the Notice on December 16, 2022, the CTU posted on the Department of Justice website information pertaining to the Notice, including non-confidential documents submitted to the CTU. The Director of Charitable Trusts contacted the Commissioners of Health and Human Services and of Insurance to alert them to the Notice and to request their input on the transaction in accordance with RSA 7:19-b, IV(b). Both the Insurance Commissioner and the Commissioner of Health and Human Services provided the CTU with helpful input.

The CTU retained Katharine London, Principal, ForHealth Consulting at UMass Chan Medical School, to conduct an analysis of the proposed

transaction, particularly with respect to its potential impact on VRH and the community it serves. Ms. London's report is attached as Attachment 1.

By letter dated January 19, 2023, in accordance with RSA 7:19-b, IV (a), the CTU required that VRH submit additional information and documentation to the CTU. On March 3, 2023, and April 13, 2023, counsel for VRH provided the requested information. All the correspondence, documents, and other information submitted by VRH and DHH pertaining to the proposed transaction collectively are considered to be the "Notice."[9]

On April 26, 2023, representatives of the CTU and the Department of Justice Consumer Protection and Antitrust Bureau ("CPAB") toured the VRH facilities and met with some members of VRH management and clinical staff and legal counsel to VRH. Thereafter, CTU representatives met with the VRH board of trustees and VRH's legal counsel.

On May 18, 2023, the CTU held a public hearing regarding the proposed transaction at Claremont Savings Bank Community Center in Claremont. The CTU offered remote access to the hearing through Zoom videoconferencing. Over 58 people attended the public hearing in person, and 26 people attended remotely.

Scott Spradling of the Spradling Group served as moderator of the public hearing. The public hearing began with presentations by representatives of VRH, DHH, and MAHHC. Ms. London then presented her findings regarding the proposed transaction.[10] The presentations were followed by a one-hour comment and question period, during which people made comments or asked questions in person or through the Zoom chat feature.

The CTU issued a news release and posted on its website a notice inviting public comment on the proposed transaction. In addition to comments received at the public hearing on May 18, 2023, the CTU received written comments from the public. The CTU also sought and obtained input from other stakeholders in the local community and in the healthcare sector.

Following the public hearing, the CTU and other representatives of the New Hampshire Attorney General's office, including representatives of CPAB, engaged in discussions with the parties regarding the terms and conditions of the proposed transaction. The parties have since agreed to enter into a Final

[9] The CTU posted to its website the correspondence and documentation submitted to the CTU by the parties, with the exception of certain documents not subject to disclosure under the New Hampshire Right to Know law, RSA Chapter 91-A.

[10] Among Ms. London's conclusions were that the transaction potentially could result in the improvement of the quality of care at VRH, a greater ability to recruit providers, and greater access for consumers to the full array of services at DHH, but that it might also create difficulty in accessing healthcare services outside the DHH system.

Judgment setting forth certain commitments by VRH and DHH. See Attachment 2. Subject to the representations made by the parties to the CTU and compliance with the Final Judgment, the Director of Charitable Trusts has concluded that the transaction complies with the criteria set forth in RSA 7:19-b and that the CTU will take no action to oppose the proposed transaction.

B. Application of the Review Standards under RSA 7:19-b

The proposed transaction constitutes a change of control under RSA 7:19-b, I (a) because under the terms of the Agreement, DHH will have the authority to elect a majority or more of the membership of the governing body of VRH. *See* RSA 7:19-b, I (c). RSA 7:19-b, II requires that the governing body of a health care charitable trust ensure that such a transaction comply with seven minimum standards. The role of the CTU is to review the proposed transaction to determine compliance with the seven minimum standards and notify the parties whether the CTU will object or take no further action with respect to the transaction. RSA 7:19-b, IV.

The following is the CTU's analysis and conclusions with respect to each of the standards set forth in RSA 7:19-b, II.

1. RSA 7:19-b, II (a): Permitted by Law

RSA 7:19-b, II (a) provides:

> The proposed transaction is permitted by applicable law, including, but not limited to, RSA 7:19–32, RSA 292, and other applicable statutes and common law; […]

As part of its public protection function, the CPAB of the New Hampshire Attorney General's office conducted a nonpublic review of the proposed transaction to examine the impact on competition for health care services in the region. *See* RSA Chapters 356 and 358-A, and related federal law. The CPAB's review included an analysis of existing overlap between the parties' service lines and facilities, existing and increase of market share and market power implicated by the proposed combination, existing market concentration in the surrounding market, and potential efficiencies to be gained. VRH and DHH have agreed to terms to ameliorate the CPAB's concerns, which have been incorporated into the Final Judgment. Provided that the parties comply with the terms of the Final Judgment, the CTU does not have a basis to conclude that the proposed transaction will give rise to a violation of consumer protection and antitrust laws.

The CTU found no evidence that the transaction otherwise would be prohibited by applicable law. Moreover, because the proposed transaction does not involve a change in the charitable purpose or a change in the administration of charitable assets, the CTU takes the position that court

approval of the transaction through a petition for *cy pres* or similar relief is not required.

2. RSA 7:19-b, II (b) Due Diligence in Structuring the Reorganization

RSA 7:19-b, II (b) provides:

> Due diligence has been exercised in selecting the acquirer, in engaging and considering the advice of expert assistance, in negotiating the terms and conditions of the proposed transaction, and in determining that the transaction is in the best interest of the health care charitable trust and the community which it serves; [...]

a. Due Diligence in Selecting the Acquirer and in Engaging and Considering the Advice of Expert Assistance and in Negotiating the Terms and Conditions

As discussed in the Report of the Attorney General, Charitable Trusts Unit Regarding the Governance of LRGHealthcare,[11] hospitals are among the largest, most complex, charitable organizations in New Hampshire. Board members of hospitals therefore must devote more time and attention to making major decisions than their counterparts in less complex charities. *See* Restatement of Charitable Nonprofit Organizations, § 2.03, cmt b. As a result, before entering into a transaction that could impact the hospital's ability to carry out its charitable mission, board members not only should apply their own particular skills and expertise in reviewing the transaction, but they should also consult with outside experts to advise them on whether the transaction is in the best interests of the charitable trust in light of its purpose.

In 2019, the VRH board engaged a consultant, Wellesley Partners, to assist the board in developing a strategic plan. The outcome of that process included a goal to develop a long-term strategy with DHH. The board also engaged the law firm of Nixon Peabody to assist the board in negotiating the terms and conditions of the transaction with DHH.

According to the VRH board, VRH explored potential affiliations with three other hospitals in New Hampshire and Massachusetts, but those hospitals were not interested in pursuing an affiliation. The board members told the CTU that DHH was a natural partner for VRH for a number of reasons, including that VRH already had a long-standing clinical and managerial relationship with DHH.

The minutes of board and executive committee meetings reflect that the board and its executive committee spent significant time discussing a potential

[11] *See* Report of the Attorney General, Charitable Trusts Unit Regarding the Governance of LRGHealthcare (April 21, 2022).

affiliation with MAHHC and DHH. The board met a number of times with the CEO of MAHHC and a representative of DHH, and the CEO and DHH representative made presentations to the board about the benefits of an affiliation. Legal counsel for VRH also repeatedly met with the board to discuss the transaction.

During the board's meeting with CTU representatives, it was clear that certain members of the board were more knowledgeable than others about the specific provisions in the Agreement. Overall, however, the board members seemed engaged and understood how the transaction with DHH potentially would benefit VRH and its patients. The board members did not appear to appreciate the potential for members of a "mirror board" with MAHHC to face a conflict of interest when considering matters that could impact either MAHHC or VRH or both.

b. Best Interest of the Health Care Charitable Trust and the Communities it Serves

RSA 7:19-b, II (b) requires that the board of directors of a health care charitable trust exercise due diligence in determining that the transaction is in the best interests of the health care charitable trust. This requirement is consistent with the board's fiduciary duty of loyalty under common law to "act in good faith and in a manner the fiduciary reasonably believes to be in the best interests of the charity in light of its purposes."[12] It is important to note that unlike the trustees of for-profit corporations, the "duty of loyalty of charitable fiduciaries is to the charity's *purposes* and thus by extension to the indefinite beneficiaries of those purposes."[13]

RSA 7:19-b requires that the board consider how the transaction would address community needs, "including the community's or communities' need for access to quality and affordable physical and mental health care services." RSA 7:19-b, II (e). Community needs may be identified in the community health needs assessments developed pursuant to RSA 7:32-f. Moreover, the concept of community needs likely includes consideration of the three outcomes that are evaluated with respect to any health care system: cost, quality, and access.[14]

Only one VRH board member voted against the transaction with DHH, and during the board meeting with CTU, she said that she opposed the transaction out of concern that it would result in a loss of services at VRH. The

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[12] Restatement of Charitable Nonprofit Organizations, § 2.02(a); *see also* Opinion of the Attorney General, Fiduciary Duty of Corporate Members of Charitable Organizations, at 3 (Feb. 13, 2017).

[13] *Id.* (emphasis supplied).

[14] *See* Community Benefit and Market Changes in New Hampshire, New Hampshire Center for Public Policy Studies (2017).

other board members indicated that VRH's experience with DHH and the experiences of MAHHC and Alice Peck Day Hospital demonstrated that when they affiliated with DHH, the services were strengthened, allowing local patients to be treated closer to home. Those board members recognized that transportation to Lebanon is difficult for many, and they said that the goal of the transaction is to bring more services into the local community.

The proposed Service Line Plan for MAHHC/VRH developed by the parties reflects that VRH will experience an increase in staffed beds from 21 to 25 and expansion of the following service lines: general surgery, oncology, behavioral health, hematology, substance use disorder treatment, orthopedics, inpatient medicine, primary care, and eye care. The plan also suggests that urology will be consolidated at MAHCC and that MAHCC will experience growth of certain service lines. The plan does not suggest that any services currently offered by VRH will be consolidated at MHMH in Lebanon.

The proposed Service Line Plan reflects no change to "Women's Health" at VRH or MAHHC. Although VRH was founded by women, it closed its labor and delivery unit in 2012. In 2022, Planned Parenthood also permanently closed its health center in Claremont. A gynecologist visits Claremont only 2–3 times per week. As a result, many women have to take time off to travel to Lebanon for pre-natal, post-natal, and other gynecological care, and there is no public transportation available.

The recruitment and retention of healthcare providers is a significant challenge for VRH. The board members, including the medical staff president, believe that the proposed transaction will aid in recruiting and retaining providers because of DHH's national reputation as a respected teaching hospital.

Although the CTU believes that the VRH exercised their best efforts to negotiate an agreement that was in the best interests of VRH and the communities it serves, additional safeguards are required to ensure that the commitments made by DHH are enforceable and that the transaction addresses the top community health needs and the need for access to quality care at a reasonable cost. Compliance with the requirement of RSA 7:19-b, II (b) therefore is met only subject to the commitments set forth in the Final Judgment.

3. RSA 7:19-b, II (c) Conflicts of Interest

RSA 7:19-b, II (c) provides:

> Any conflict of interest, or any pecuniary benefit transaction as defined in this chapter, has been disclosed and has not affected the decision to engage in the transaction; […]

Pecuniary benefit transactions are financial conflict-of-interest transactions involving a charitable organization's directors, their family members, their employers, or their businesses. RSA 7:19-a. Pecuniary benefit transactions are not prohibited under New Hampshire law, provided that they are in the best interest of the charity and certain conditions are met. These conditions include the exclusion of the interested board member from deliberations and votes and the disclosure of the transaction to the Director of Charitable Trusts. RSA 7:19-a, II.

In the Notice, VRH certified that there were no disclosed or known conflicts of interest or pecuniary benefit transactions involved in the proposed transaction with DHH. The CTU has not identified any conflict of interest or pecuniary benefit transaction with respect to the proposed transaction.

4. RSA 7:19-b, II (d) Fair Value of Transaction

RSA 7:19-b, II (d) provides:

> The proceeds to be received on account of the transaction constitute fair value therefor; […]

The proposed transaction between VRH and DHH does not involve a sale, and RSA 7:19-b, II (d) therefore is inapplicable to the proposed transaction.

5. RSA 7:19-b, II (e) Use of Charitable Assets

RSA 7:19-b, II (e) provides:

> The assets of the health care charitable trust and any proceeds to be received on account of the transaction shall continue to be devoted to charitable purposes consistent with the charitable objects of the health care charitable trust and the needs of the community which it serves; […]

Under the terms of the Agreement, VRH will retain exclusive control of all donor-restricted gifts pledged, accumulated, or distributed to VRH. However, VRH's unrestricted gifts may be used for the benefit of the "Service Area" which, under the terms of the Agreement, will be expanded to include all of Windsor County, Vermont.[15] The ability of VRH to conduct fundraising in the future (especially for its capital projects) may also be impacted by the obligation under the terms of Agreement to conduct fundraising for the DHH system.

[15] According to the Community Benefits Report submitted to the CTU on April 18, 2023, VRH's current service area is Sullivan County, New Hampshire, and several bordering towns in Vermont, including Windsor, Weathersfield, and Springfield (but not all of Windsor County, Vermont).

Additional commitments are required to ensure that the charitable assets of VRH are devoted to VRH's charitable purpose in New Hampshire and to ensure that DHH exercises its fiduciary responsibilities over EHR. *See Opinion of the Attorney General*, Fiduciary Duty of Corporate Members of Charitable Organizations, at 3 (Feb. 13, 2017). Compliance with the requirement of RSA 7:19-b, II (e) therefore is met only subject to the commitments set forth in the Final Judgment.

6. RSA 7:19-b, II (f) Control of the Proceeds

RSA 7:19-b, II (f) provides:

> If the acquirer is other than another New Hampshire health care charitable trust, control of the proceeds shall be independent of the acquirer; [...]

In this case, the "acquirer" is a New Hampshire health care charitable trust. 7:19-b, II (f) therefore is inapplicable to the proposed transaction between VRH and DHH.

7. RSA 7:19-b, II (g) Notice and Hearing

RSA 7:19-b, II (g) provides:

> Reasonable public notice of the proposed transaction and its terms has been provided to the community served by the health care charitable trust, along with reasonable and timely opportunity for such community, through public hearing or other similar methods, to inform the deliberations of the governing body of the health care charitable trust regarding the proposed transaction.

The purpose of the "reasonable public notice" requirement is to ensure that prior to finalizing and voting in favor of an acquisition or change of control transaction, the board considers input from the public. This requirement recognizes that the ultimate beneficiary of a health care charitable trust is the public, and that the board should consider the interests of the communities served by the health care charitable trust in its deliberations.

VRH held informational sessions for its employees and medical staff, and on September 8, 2022, VRH held a public listening session at Claremont Savings Bank in Claremont, New Hampshire and virtually via Zoom.[16] Patricia

[16] Although the purpose of holding a listening session is to elicit public comments to inform the deliberations of the board, RSA 7:19-b, III(g), the parties advertised the session as an opportunity for the public to hear from the parties about "how Valley Regional Hospital and Dartmouth Hitchcock Health are coming together to serve you better." A video of the public listening session is available on the VRH website.

Putnam, Chair of the VRH board, and Dr. Jocelyn Caple, MD, VRH's Interim President, CEO, and CMO, presented at the public listening session on behalf of VRH. Dr. Joanne Conroy, MD, President and CEO of DHH, and Dr. Joseph Perras, MD, President, CEO, and CMO of MAHHC, presented at the public listening session as well. It is not clear how many board members attended the listening session, but few attendees asked any questions or made any comments. No changes were made to the Integration Agreement as a result of the public listening session.

III. Conclusions and Determination.

After reviewing the evidence, the Director of Charitable Trusts finds that the VRH board substantially complied with the minimum standards set forth in RSA 7:19-b, II. However, the decision of the Director of Charitable Trusts to take **no further action** with respect to the proposed transaction is subject to the following representations and conditions:

1. VRH and DHH shall comply with the terms of the Final Judgment into which the parties have entered with the New Hampshire Attorney General's office. The provisions of the Final Judgment are hereby incorporated into this report. *See* Attachment 2.
2. VRH and DHH represent that the statements made and documents provided in the Notice are true and correct. They further represent that the transaction will be implemented in accordance with the Notice and the Final Judgment.

ATTACHMENT 1

forHealth™ CONSULTING at UMass Chan Medical School

Proposed Transaction:
Consumer Fact Sheet

Valley Regional Hospital Public Hearing

On December 14, 2022, Valley Regional Hospital (VRH) filed a notice of a proposed transaction by and among Valley Regional Healthcare, Inc. (VRHC), Valley Regional Hospital, Inc., and Dartmouth-Hitchcock Health (D-HH). The parties propose that D-HH become the sole corporate member* of VRH.

Potential Benefits[1]

D-HH and VRH say the transaction would benefit the community by:

- Improving VRH's long-term financial stability
- Consolidating and streamlining administrative functions, such as combining leadership roles, establishing a uniform electronic medical records system, combining human resources/staffing functions, and lowering costs through bulk purchasing arrangements
- Expanding and improving healthcare options at VRH, such as behavioral health and substance use disorder treatment, hematology and oncology, general surgery, orthopedics, inpatient and primary care, and eye care
- Improving retirement and other benefits for VRH employees through integration into the D-HH system

Potential Concerns

Stakeholders noted some concerns about the proposed transaction, including the possibility of:

- The difficulty finding a provider outside of the D-HH system
- Healthcare service lines consolidated at only one service location, requiring patients to travel further for care
- The loss of local decision-making and responsiveness to community needs at VRH
- Virtually identical Boards of Trustees at VRH and Mount Ascutney Hospital and Health Center (MAHHC) leading to further integration and less local control of VRH and MAHHC in the future

*A "corporate member" is an entity that has a controlling or voting interest in a corporation.

Comments regarding the proposed transaction may be sent to the Director of Charitable Trusts, Department of Justice, 33 Capitol St., Concord, NH 03301 or by email to charitabletrustsunit@doj.nh.gov.

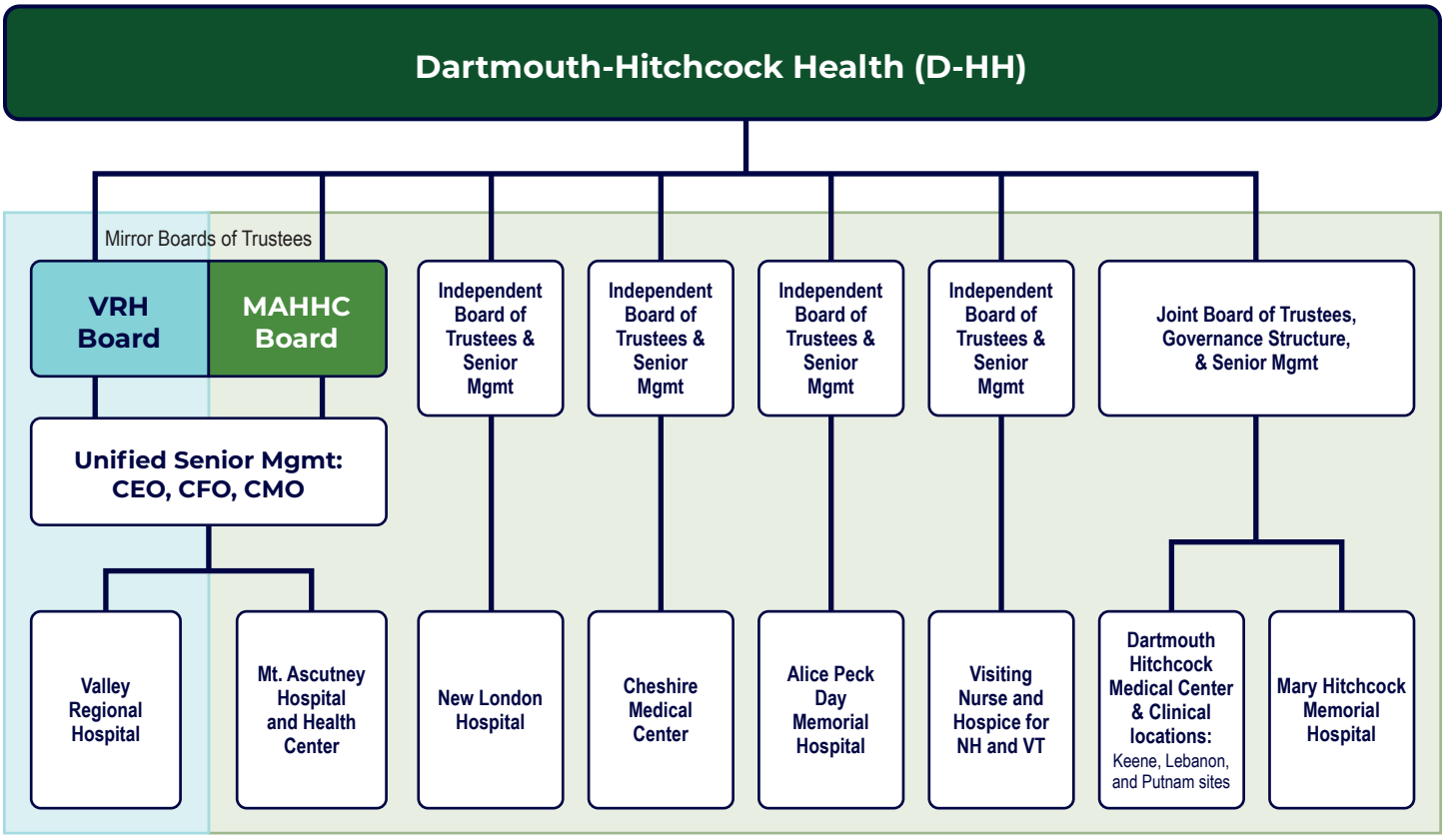
More information about the proposed transaction is available at:
https://www.doj.nh.gov/charitable-trusts/valley-regional-dartmouth-health.htm

Proposed Transaction: Corporate Governance and Boards[2]

D-HH will become the sole corporate member of Valley Regional Hospital (VRH).

- Both VRH and MAHHC will be managed by a unified senior management team comprised of a single chief executive officer (CEO), chief medical officer (CMO), and chief financial officer (CFO)
- VRH and MAHHC will be governed by virtually identical "mirror" Boards of Trustees
- VRH's board and MAHHC's board will be comprised of:

  - Seven trustees nominated by VRH and approved by the D-HH Board
  - Seven trustees nominated by MAHHC and approved by the D-HH Board
  - The single CEO of VRH & MAHHC
  - The CEO of D-HH (or designee) and additional trustees appointed by D-HH, comprising up to one-third (1/3) of the total Board members
  - Medical Staff President of VRH or MAHHC (this role is the only difference between the two boards)



Focus on Key System Members: Hospitals at a Glance[3]

Alice Peck Day Memorial Hospital (APDMH), New London Hospital (NLH), and MAHHC are all members of D-HH; VRH is not. These four critical access hospitals are of similar size*.

		Dartmouth-Hitchcock Health		
	Valley Regional Hospital (FY 2020)	**Mt. Ascutney Hospital** (FY 2020)	**Alice Peck Day Memorial Hospital** (FY2020)	**New London Hospital** (FY2020)
Total Number of Staffed Beds	21	35	24	25
Bed Occupancy Rate**	40.8%	73.8%	52.3%	56.2%
Total Charity Care*** (millions)	1.5	.3	.4	1.6
Total Charity Care (% of Total Revenue)	.030%	.005%	.005%	.020%
Total Community Benefits (millions)****	5.2	N/A	5.1	6.1
Total Expenses (millions)	46.7	55.8	77.2	72.6
Total Net Patient Service Revenue (millions)	41.8	45.0	78.7	61.9
Total Revenue (millions)	**49.6**	**62.0**	**86.8**	**72.2**

* Comparison of hospitals only. Does not include physician practices.

** Bed occupancy rate is computed by dividing patient days by the number of total bed days available, both available within the S-3 Filing of the CMS 2552 Cost Report of each hospital.

*** Includes charity care costs related to both insured and uninsured patients.

**** Includes community health services, health professions education, subsidized health services, research, financial contributions, community-building activities, community benefit operations, and charity care.

Hospital Payment Levels[4]

This table compares the average payment each hospital receives from the three largest private health plans to the state median payment for the same sets of services.

MAHHC is located in Vermont and therefore does not report payment amounts to New Hampshire.

Higher	Health plan pays hospital a rate more than ***10% higher*** than the state median
Similar	Health plan pays hospital a rate ***similar to*** the state median
Lower	Health plan pays hospital a rate more than ***10% lower*** than the state median
N/A	Insufficient sample size (fewer than 50 events in the calendar year)

Private Insurance Payments			Dartmouth-Hitchcock Health	
		Valley Regional Hospital	Alice Peck Day Memorial Hospital	New London Hospital
Emergency Visits	Anthem NH	Higher	Higher	Similar
	CIGNA	Lower	Lower	Lower
	Harvard Pilgrim HC	Similar	Lower	Lower
Office Visits	Anthem NH	Lower	Similar	Lower
	CIGNA	Lower	Similar	Lower
	Harvard Pilgrim HC	Lower	Lower	Lower
Outpatient Tests and Procedures*	Anthem NH	N/A	Higher	N/A
	CIGNA	N/A	N/A	N/A
	Harvard Pilgrim HC	N/A	N/A	N/A
Radiology Services	Anthem NH	Higher	Higher	Higher
	CIGNA	Higher	Higher	Higher
	Harvard Pilgrim HC	Higher	Higher	Higher

This table compares the discounted rate that each hospital charges uninsured patients to the state median rate for the same sets of services. VRH gives more generous discounts to uninsured patients for emergency services than the other hospitals.

Higher	Hospital charges uninsured patient a rate more than ***10% higher*** than the state median
Similar	Hospital charges uninsured patient a rate ***similar to*** the state median
Lower	Hospital charges uninsured patient a rate more than ***10% lower*** than the state median
N/A	Insufficient sample size (fewer than 50 events in the calendar year)

Estimated Uninsured Prices**	Dartmouth-Hitchcock Health		
	Valley Regional Hospital	Alice Peck Day Memorial Hospital	New London Hospital
Emergency Visits	Lower	Similar	Lower
Office Visits	Lower	Lower	Lower
Outpatient Tests and Procedures*	N/A	Higher	N/A
Radiology Services	Higher	Higher	Higher

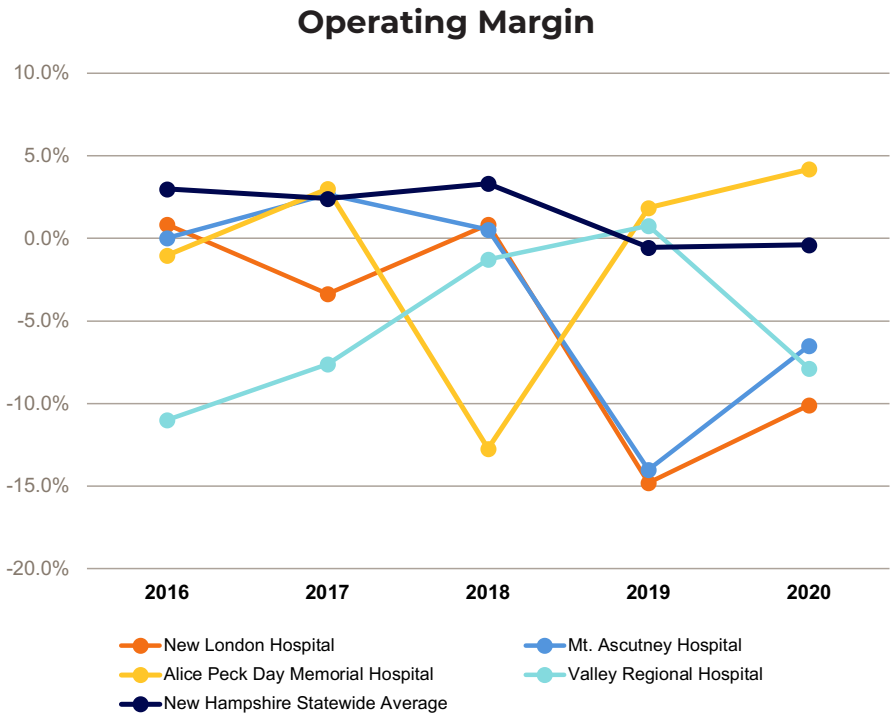
* "Outpatient Tests and Procedures" does not include radiology services or facility fees for ED and office visits.

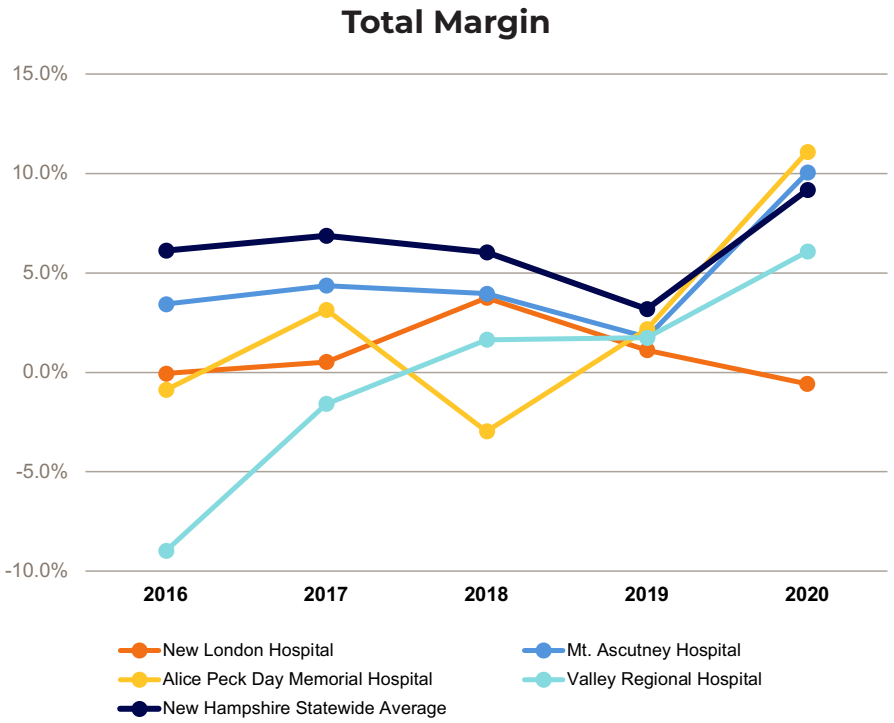
** NH HealthCost estimates the prices a hospital offered to uninsured individuals based on the prices paid by private insurers and the hospital's discount policy for uninsured patients.

Hospital Financial Analysis[5]

- VRH's operating and total margins were very low in federal filing year (FFY) 2016 and improved through FFY 2019. Its operating margin dropped in FFY 2020, while its total margin improved, suggesting that it drew on non-operating sources of revenue. VRH's operating margin was negative in every year reviewed except FFY 2019, while its total margin was positive from FFY 2018 through 2020.
- In comparison, APDMH, NLH and MAHHC's operating margins were more stable in FFY 2016 and 2017, dropped deeply in FFY 2018 or 2019 and then improved. Their total margins were generally positive during this period. APDMH and MAHHC's total margins increased in FFY 2020 in alignment with VRH's.
- The statewide average operating margin was more steady but was slightly negative in FFYs 2019 and 2020. The statewide total margin remained positive throughout this period and improved in FFY 2020.

Data included in this analysis only pertain to the hospitals, not any owned or affiliated physician practices.





Hospital Quality Snapshot – Comparison

VRH[6] and NLH[7] performed similarly on quality measures compiled by CMS Hospital Care Compare. APDMH[8] and MAHHC[9] scored significantly better than the other two hospitals; MAHHC also had the highest patient experience score of 5 stars.

		Dartmouth-Hitchcock Health		
Measure*	**Valley Regional Hospital**	**Mt. Ascutney Hospital**	**Alice Peck Day Memorial Hospital**	**New London Hospital**
Quality of Care Measures Better Than Average	**2** of 10	**8** of 10	**8** of 10	**2** of 10
Quality of Care Measures Near Average	**5** of 10	**2** of 10	**2** of 10	**5** of 10
Quality of Care Measures Worse Than Average	**3** of 10	**0** of 10	**0** of 10	**3** of 10
Overall Rating** *(out of 5 stars)*	★★★★	★★★★	N/A	★★★★
Patient Experience Summary Star Rating*** *(out of 5 stars)*	N/A	★★★★★	★★★★	★★★★
Rate of readmission after discharge from hospital******	**14%**	**16%**	**15%**	**14%**

* Measures highlighted in shades of green are scores higher than the state or national average, shades of yellow are scores at or near the state or national average, and shades of red are scores lower than the state or national average.

** This measure summarizes more than 100 measures of mortality, safety of care, readmission, patient experience, effectiveness of care, timeliness of care, and efficient use of medical imaging.

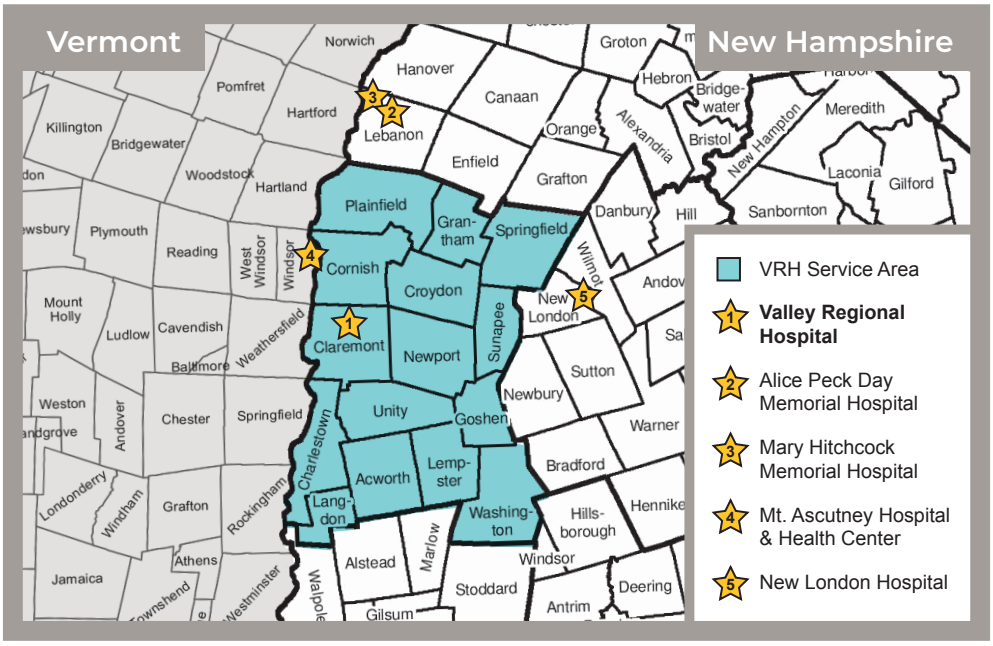
*** This measure summarizes how patients recently discharged from the hospital responded to a survey about their hospital experience. The survey asked questions like how well a hospital's doctors and nurses communicated with the patient.

**** Share of patients readmitted to the hospital within 30 days of discharge.

Communities Served by Valley Regional Hospital[10]

The communities shaded in **teal** are the ones VRH identifies as its primary service area.*

* This map shows the communities reported by the hospital as its primary service area; it does not reflect an anti-trust analysis.



Community Health Profile[11]

Sullivan County performed similarly to the state in most health statistics. However, Sullivan County does have some health challenges, such as those highlighted below.

Measure	Sullivan County	New Hampshire
Ratio of population to dentists	**2,550:1**	**1,300:1**
Ratio of population to mental health providers	**500:1**	**290:1**

Community Health Needs Assessment Priorities[12]

In its 2021 Community Health Needs Assessment, VRH identified the following priority health needs of the community:

1. Availability of mental health services
2. Cost of healthcare services and affordability of health insurance
3. Alcohol and drug use prevention, treatment and recovery
4. Socio-economic conditions affecting health and well-being, such as housing affordability, access to healthy foods, and affordable childcare.
5. Affordability and availability of dental care services
6. Prevention of child abuse and neglect

Community Health Priorities

The VRH Community Health Needs Assessment highlights the community members' concerns regarding health priorities. The section entitled Input on Health Issues and Priorities reported responses to a survey that asked community members to select the most pressing health issues out of a list of 27 potential topics. The Needs Assessment reported these top five health concerns:

1. Ability to get mental health services (52% of responses)
2. Cost of health care services (46% of responses)
3. Cost of health insurance (43% of responses)
4. Cost of prescription drugs (37% of responses)
5. Misuse and addiction to drugs and alcohol (33%)

Citations:

[1] NH Department of Justice. Pending Hospital Transaction between Valley Regional Health and Dartmouth-Hitchcock Health, Joint Notice, Sections I and V. Available at https://www.doj.nh.gov/charitable-trusts/health-care.htm. Accessed on April 15, 2023.

[2] Information obtained from documents submitted by Valley Regional Hospital to the Director of Charitable Trusts, New Hampshire Attorney General's Office, as notice for a proposed transaction involving Dartmouth-Hitchcock Health, available at: https://www.doj.nh.gov/charitable-trusts/valley-regional-dartmouth-health.htm. Accessed on April 14, 2023.

[3] Data retrieved from CMS Hospital Form 2552-10 Cost Reports for NH Acute Care Facilities for FY2016 - FY2020. Bed occupancy rate calculation is derived from CMS: https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/downloads/Accessing_Data_and_Sample_Computations.pdf. Each hospital reports data on the CMS 2552-10 Cost Report by its own federal filing year. A hospital's federal filing year begins on the first day of the hospital's fiscal year on or after the beginning of the federal fiscal year (October 1). For example, federal filing year 2020 data for Alice Peck Day Memorial Hospital and New London Hospital encompass activity from July 1, 2020, through June 30, 2021; while federal filing year 2020 data for Mt. Ascutney Hospital and Valley Regional Hospital encompass activity from October 1, 2019 through September 30, 2020.

[4] New Hampshire Comprehensive Health Care Information System (NH CHIS). NH CHIS Group Medical Plans and Uninsured Claims only, FY2020 Q2. Weighted average of median payment amounts compiled by the authors and staff of the New Hampshire Insurance Division. Authors calculated the median payment by insurer by service for each hospital and median payment by insurer by service for the state as a whole. The chart shows the average of the median payment the hospital received for each service category, weighted by the hospital's service mix, relative to the average state median payment amount for each service weighted by the hospital's service mix.

[5] Data retrieved from CMS Hospital Form 2552-10 Cost Reports for NH Acute Care Facilities for FY2016 - FY2020.

[6] Medicare Hospital Compare: Valley Regional Hospital. Available at https://www.medicare.gov/care-compare/details/hospital/301308?city=Claremont&state=NH&zipcode=&measure=hospital-patient-surveys#ProviderDetailsQualityIndicatorsContainer. Accessed on April 12, 2023.

[7] Medicare Hospital Compare: New London Hospital. https://www.medicare.gov/care-compare/details/hospital/301304?city=New%20London&state=NH&zipcode=&measure=hospital-patient-surveys#ProviderDetailsQualityIndicatorsContainer. Accessed on April 12, 2023.

[8] Medicare Hospital Compare: Alice Peck Day Memorial Hospital. https://www.medicare.gov/care-compare/details/hospital/301305?city=Claremont&state=NH&zipcode=&measure=hospital-patient-surveys#ProviderDetailsQualityIndicatorsContainer. Accessed on April 12, 2023.

[9] Medicare Hospital Compare: Mt. Ascutney Hospital. https://www.medicare.gov/care-compare/details/hospital/471302?id=aa4de819-f8e5-4943-b842-a6e1b7dc4832&state=VT. Accessed on April 12, 2023.

[10] Valley Regional Healthcare, Community Needs Assessment 2021. Available at https://vrh.org/wp-content/uploads/2021/09/2021-Valley-Regional-Hospital-Community-Health-Needs-Assessment-final-1-min.pdf. Accessed on April 7, 2023.

[11] Robert Wood Johnson Foundation County Health Rankings and RoadMaps. Available at https://www.countyhealthrankings.org/explore-health-rankings/new-hampshire/sullivan. Accessed on March 10, 2023.

[12] Valley Regional Healthcare, Community Health Needs Assessment 2021.

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Alice Peck Day Memorial Hospital

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May 2023

Table of Contents

Executive Summary

This report profiles Alice Peck Day Memorial Hospital (APDMH) on several dimensions as summarized and detailed below.

Overview

APDMH is a 24-bed acute care facility located in Lebanon, New Hampshire (NH). The hospital provides emergency care and clinical specialties including dermatology, emergency services, family medicine, among other services.

Community Benefits

APDMH provided $5 million in charity care and $120,295 in other community benefit services, as noted in its FY 2020 Community Benefits Report. APDMH's charity care costs for uninsured patients decreased at a significantly faster rate than the statewide rate over the five years reviewed, from federal filing year (FFY) 2016 through 2020.[1]

Financial Status

APDMH produced positive operating and total margins for FFYs 2017, 2019 and 2020; however, it experienced a serious operating loss in FFY 2018. APDMH's expenses and revenues increased during the period FFY 2016 through FFY 2020, even while its inpatient service volume (total hospital days and discharges) decreased. The authors based these findings on an analysis of CMS Hospital Cost Report (Form 2552-10) data for the hospital's FFYs 2016-2020.* CMS requires hospitals to file financial data on these reports annually in a consistent format that produces a comparable set of measures.[2]

Cost

APDMH's outpatient prices were lower than the state average for some services and higher for other services. APDMH's payments from Anthem were higher than the statewide average in three of the four service categories and similar to the state average for the fourth service. APDMH's payments from Harvard Pilgrim were lower than the state average for two service categories. The estimated prices APDMH charged to uninsured patients were lower than the state median for office visits, but higher for outpatient tests and procedures and radiology services. The authors developed this assessment from an analysis of FY2022 Q2 data submitted to the New Hampshire Comprehensive Health Care Information System (CHIS).[3]

Quality

APDMH scored well on most quality measures. On the 10 Centers for Medicare and Medicaid Services (CMS) Hospital Care Compare patient experience scores, APDMH scored better than the state and national averages on eight measures and at or near the state and national averages on two measures. APDMH received 4 out of 5 stars for overall patient experience.[4] On two other quality measures reported on NH HealthCost, APDMH scored similar to the state average on one measure and worse than average on the other.[5]

Contents of the Report

This report provides the following information about APDMH:

- Service profile, including general informational statistics, services offered, cost of charity care and community benefits, and a summary of quality
- Multi-year profile of financial and utilization comparison statistics
- Pricing comparison of the average payment APDMH receives for outpatient services it provides compared to the state median payment for the same sets of services
- Outline of performance on healthcare quality and safety measures compiled by NH HealthCost
- Patient experience survey ratings from CMS Hospital Care Compare

Alice Peck Day Memorial Hospital Service Profile

General Hospital Information	
Type of Facility	Acute Care
Total Staffed Beds[6]	24
Total Available Beds[7]	24
Bed Occupancy Rate*	52.2%
Accredited by The Joint Commission[6]	No
Annual Hospital Discharges[6]	466

Hospital Services Offered[8]

- Anesthesiology
- Cardiopulmonary
- Emergency Services
- Gastroenterology
- General Surgery
- Gynecology
- Infusion Clinic
- Inpatient Stay
- Integrative Medicine
- Laboratory
- Medical Surgical
- Neurosurgery
- Obstetrics
- Occupational Health
- Oral Surgery
- Pain and Physiatry
- Physical, Occupational, and Speech Therapies
- Plastic and Reconstructive Surgery
- Sleep Health

Charity Care and Other Community Benefits[9]

The table below offers a snapshot of the charity care and other community benefits provided to the greater Lebanon community by APDMH. All information derives from APDMH's FY 2021 Community Benefit Report.

Unreimbursed Costs 2020	Benefits Provided	Financial Benefit
	(1) Financial Assistance and Means-Tested Government Programs	$4,990,509
	(2) Other Community Benefits Costs	$120,295
	(3) Community Building Activities	$21,787
	Total Unreimbursed Community Benefit Expenses	$5,132,591

Quality Statistics Summary

The table below offers a view of APDMH's performance on quality-of-care scores from two different sources: NH HealthCost and CMS Hospital Care Compare.

Source	*Measure***	*Score*
CMS Hospital Care Compare[10]	Quality of Care Measures Better Than Average	**8 out of 10**
	Quality of Care Measures Near Average	**2 out of 10**
	Quality of Care Measures Worse Than Average	**0 out of 10**

	Overall Rating* **	**N/A (information not available)**
	Patient Survey Rating**	**4 out of 5 stars**
	Unplanned readmission rating*****	No different than national rate

**Bed occupancy rate is computed by dividing patient days by the number of total bed days available, both available within the S-3 Filing of the CMS 2552 Cost Report of each hospital.*

***Measures highlighted in shades of green are scores higher than the state or national average, shades of yellow are scores at or near the state or national average, and shades of red are scores lower than the state or national average.*

****This measure summarizes more than 100 measures of mortality, safety of care, readmission, patient experience, effectiveness of care, timeliness of care, and efficient use of medical imaging.*

*****This measure summarizes how patients recently discharged from the hospital responded to a survey about their hospital experience. The survey asked questions like how well a hospital's doctors and nurses communicated with the patient.*

******Rate of patients readmitted to the hospital within 30 days of discharge*

Alice Peck Day Memorial Hospital Financial and Utilization Statistics

The two tables below provide a multi-year financial comparison profile based on analysis of Form 2552-10 data for the hospital's FFYs 2016-2020.[11]* CMS requires hospitals to file financial data on these reports in a consistent format that produces a comparable set of measures. APDMH's inpatient service volume (total hospital days and discharges) decreased during this period, while the state average remained more stable. Even though the hospital's inpatient service volume decreased, its overall expenses and revenue increased. The hospital produced positive operating and total margins in FFYs 2017, 2019 and 2020; however, it experienced a serious operating loss in FFY 2018. While the hospital's operating and total margins exceeded the state average in FFY 2020, its average operating and total margins for the entire FFY 2016-2020 period were lower than the statewide average. Trend values highlighted in green are better than the state average; those highlighted in red are worse.

Federal Filing Year*	2016	2017	2018	2019	2020	Average '16-'20 Annual Change	Statewide '16-'20 Average Annual Change
Total Hospital Discharges [S-3 Col 15 Ln 14] **	1,161	1,005	855	684	466	-14.97%	-1.49%
Total Hospital Days [S-3 Col 8 Ln 14]	5,482	5,570	4,878	4,349	4,381	-5.02%	0.15%
Charity Care Costs (Uninsured Patients) [S-10 Col 1 Ln 23]	$238,676	$327,489	$168,596	$1,775	.	.	7.95%
Charity Care Costs (Insured Patients) [S-10 Col 2 Ln 23]	.	.	.	.	$363,629	.	11.75%
Total Unreimbursed and Uncompensated Care [S-10 Col 1 Ln 31]	$4,472,740	$3,580,402	$3,478,711	$4,438,583	$5,326,577	4.77%	9.51%
Total Operating Expenses [G-2 Col 2 Ln 43]	$62,107,890	$69,307,000	$74,229,000	$71,332,791	$77,197,000	6.07%	5.52%
Total Other Expenses [G-3 Ln 28]	$486,443	$20,000	.	.	.	.	-16.72%
Total Expenses [Total Operating Expenses + Total Other Expenses]	$62,594,333	$69,327,000	$74,229,000	$71,332,791	$77,197,000	5.83%	-11.21%
Total Inpatient Charges [C Pt 1 Col 6 Ln 202]	$30,026,678	$24,333,168	$29,573,158	$24,495,920	$24,554,729	-4.56%	5.89%
Total Outpatient Charges [C Pt 1 Col 7 Ln 202]	$52,974,346	$65,551,033	$60,578,906	$62,105,431	$91,514,051	18.19%	8.12%

Federal Filing Year*	2016	2017	2018	2019	2020	Average '16-'20 Annual Change	Statewide '16-'20 Average Annual Change
Net Patient Service Revenue [G-3 Ln 3]	$61,250,499	$69,778,000	$64,094,000	$65,496,000	$78,673,000	7.11%	2.72%
Net Income from Patient Services [G-3 Ln 5]	-$857,391	$471,000	$10,135,000	-$5,836,791	$1,476,000	-68.04%	-245.10%
Other Income: Other [G-3 Ln 24.00]	$703,871	$1,697,000	$1,748,000	$7,179,000	$1,905,000	42.66%	27.13%
Total Other Hospital Income [G-3 Ln 25]	$797,934	$1,800,000	$7,997,000	$7,428,000	$8,150,000	230.35%	43.35%
Total Hospital Net Income [G-3 Ln 29]	-$545,900	$2,251,000	-$2,138,000	$1,591,209	$9,626,000	-465.83%	21.21%
Total Revenue [Net Patient Service Revenue + Total Other Hospital Income]	$62,048,433	$71,578,000	$72,091,000	$72,924,000	$86,823,000	9.98%	5.89%

Federal Filing Year*	2016	2017	2018	2019	2020	Average '16-'20 Margin	Statewide Average '16-'20 Margin
Operating Margin***	-1.03%	3.01%	-12.74%	1.85%	4.20%	-0.94%	
Statewide Industry Average****	3.00%	2.41%	3.32%	-0.55%	-0.39%		1.56%
Total Margin*****	-0.88%	3.14%	-2.97%	2.18%	11.09%	2.51%	
Statewide Industry Average****	6.13%	6.87%	6.03%	3.18%	9.17%		6.28%

**Data included in this analysis only pertain to the hospitals themselves, not to any physician practices owned by the hospital or the hospital systems each facility is associated with. Data for FFYs 2016-2020 are derived from each hospital's CMS 2552-10 Cost Report. Data are reported by each hospital's federal filing year. A hospital's federal filing year begins on the first day of the hospital's fiscal year on or after the beginning of the federal fiscal year (October 1). For example, federal 2020 data for APDMH encompass activity from July 1, 2020, through June 30, 2021.*

***Notations made in brackets "[ ]" reference the 2552-10 worksheet data source.*

****Operating Margin is calculated as {Net Patient Service Revenue plus Other Income (Other) less Total Operating Expenses less Total Other Expenses} divided by {Net Patient Service Revenue plus Other Income (Other)}.*

*****The authors calculated a combined margin for all New Hampshire acute care hospitals using data reported on the CMS Hospital Form 2552-10 Cost Reports for New Hampshire acute care hospitals.*

******Total Margin is calculated as Total Hospital Net Income divided by {the sum of Net Patient Service Revenue plus Total Other Hospital Income}.*

Alice Peck Day Memorial Hospital Estimated Outpatient Visit Pricing

The following chart shows the average payment APDMH received for services it provided in FY2022 Q2, compared to the state median payment for the same sets of services. The hospital's payments from private insurers varied across service categories. APDMH received payments lower than the statewide average for emergency visits and office visits, and it received payments higher than the statewide average for outpatient tests and radiology. The payments it received from Anthem were higher than the statewide average for three of four categories. The price APDMH charged to uninsured patients was lower than the state median for office visits, but higher for emergency visits, outpatient services, and radiology services. Amounts highlighted in green are lower than the state median; amounts highlighted in red are higher than the state median. The authors developed this assessment from an analysis of FY2022 Q2 data submitted to the NH Comprehensive Health Care Information System (CHIS).[12]

Event Type	Alice Peck Day Memorial Hospital			
	State Number of Events	*APDMH Number of Events*	*Payments to APDMH (weighted median)*	*Payments to APDMH if APDMH received the statewide median payment for its services*
Emergency Visits				
Anthem – NH	9,239	135	$550.03	$332.27
CIGNA	3,381	55	$456.00	$529.67
Harvard Pilgrim HC	5,489	60	$427.25	$484.90
Other Medical Insurance	2,414	19	N/A**	$577.32
Uninsured*	20,523	269	$373.89	$367.54
Office Visits				
Anthem – NH	347,038	1,618	$163.96	$171.87
CIGNA	88,211	1,087	$171.26	$178.84
Harvard Pilgrim HC	208,442	1,522	$135.43	$185.87
Other Medical Insurance	71,696	197	$176.12	$182.16
Uninsured*	715,394	4,424	$177.21	$252.12
Outpatient Tests and Procedures				
Anthem – NH	15,031	67	$3,260.61	$2,044.76
CIGNA	4,060	36	N/A**-	$1,190.28
Harvard Pilgrim HC	7,468	45	N/A**-	$1,704.33
Other Medical Insurance	2,757	4	N/A**-	$3,089.50
Uninsured*	31,059	164	$3,052.15	$2,405.91
Radiology Services				
Anthem – NH	61,083	486	$831.37	$412.10
CIGNA	17,079	144	$825.96	$590.65
Harvard Pilgrim HC	33,724	209	$1,009.91	$536.18
Other Medical Insurance	12,043	21	N/A**-	$463.26
Uninsured*	129,855	1,001	$943.95	$753.15

** NH HealthCost estimates the prices a hospital offers to uninsured individuals based on the prices paid by private insurers and the hospital's discount policy for uninsured patients.*

*** Weighted medians could not be calculated due to small sample size (fewer than 50 events). Source: Authors' analysis of NH Comprehensive Health Care Information System (CHIS) Group Medical Plans and Uninsured Claims only, FY2022 Q2. Authors calculated the median payment by insurer by service for each hospital and median payment by insurer by service for the state as a whole. The chart shows the average of the median payment the hospital received for each service category, weighted by the hospital's service mix. The chart compares this amount to the average state median payment amount for each service weighted by the hospital's service mix.*

Quality of Care at Alice Peck Day

The tables below show APDMH's patient experience and quality of care scores from CMS Hospital Care Compare[13] (first table) and NH HealthCost[14] (second table). The hospital patient survey, known as the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), is a national survey instrument that is used to measure patient experiences at their respective hospitals for the year ending March 2022. The results are a product of survey responses regarding the hospital experience of recently discharged patients. On the 10 CMS Hospital Care Compare patient experiences scores, APDMH scored above average (green) on eight of the measures, and around average (yellow) on two of the measures.

In addition, NH HealthCost reports two additional measures for APDMH. Lastly, in terms of the "Timely Care" category, APDMH scored near average in time spent in the Emergency Department Before Being Discharged. In the "Safe Care" category, APDMH scored worse than average in the rate of patients infected with C.diff while at the hospital. The hospital did not have sufficient volume to support the calculation of additional quality measures.

Patient Experience

Measure Description	Alice Peck Day Memorial Hospital*	NH Average	National Average
Patients who reported that their nurses "Always" communicated well	83%	81%	79%
Patients who reported that their doctors "Always" communicated well	85%	79%	80%
Patients who reported that they "Always" received help as soon as they wanted	71%	65%	66%
Patients who reported that staff "Always" explained about medicines before giving it to them	64%	62%	62%
Patients who reported that their room and bathroom were "Always" clean	81%	73%	72%
Patients who reported that the area around their room was "Always" quiet at night	54%	54%	62%
Patients who reported that YES; they were given information about what to do during their recovery at home	92%	88%	86%
Patients who "Strongly Agree" they understood their care when they left the hospital	60%	51%	51%
Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)	81%	70%	71%

Patients who reported YES; they would definitely recommend the hospital	86%	71%	70%

Timely Care

Time Spent in the Emergency Department Before Being Discharged	NEAR AVERAGE	164 min state average 159 min

Patients Infected with C.diff While at Hospital	MORE THAN AVERAGE	1. 7 state average: 1.0

Citations

[1] Alice Peck Day Memorial Hospital, FY 2021 Community Benefit Report. Available at https://www.alicepeckday.org/sites/default/files/2022-12/FY21-Community-Benefits-Report-with-Addendum.pdf Accessed on March 8, 2023.

[2] Data retrieved from CMS Hospital Form 2552-10 Cost Reports for NH Acute Care Facilities for FY2016 - FY2020. Data are reported by each hospital's federal filing year. A hospital's federal filing year begins on the first day of the hospital's fiscal year on or after the beginning of the federal fiscal year (October 1). For example, federal filing year 2020 data for APDMH encompass activity from July 1, 2020 through June 30, 2021. Data included in this analysis only pertain to the hospitals themselves, not to any physician practices owned by the hospital or the hospital systems with which each facility is associated.

[3] New Hampshire Comprehensive Health Care Information System (NH CHIS). NH CHIS Group Medical Plans and Uninsured Claims only, FY2020 Q2. Weighted average of median payment amounts compiled by the authors. Authors calculated the median payment by insurer by service for each hospital and median payment by insurer by service for the state as a whole.

[4] Medicare Hospital Care Compare: Alice Peck Day Memorial Hospital. https://www.medicare.gov/care-compare/details/hospital/301305?id=21cd46eb-75a4-45e5-9a77-0826c1b61ea8&city=Claremont&state=NH&zipcode= . Accessed on March 17, 2023.

[5] NH HealthCost: Valley Regional Hospital (2023). Available at https://nhhealthcost.nh.gov/provider/alice-peck-day-memorial-hospital/quality?carrier=uninsured. Accessed on March 3, 2023.

[6] Alice Peck Day Memorial Hospital:. Available at https://www.alicepeckday.org/about . Accessed on March 8, 2023.

[7] Data retrieved from CMS Hospital Form 2552-10 Cost Reports for NH Acute Care Facilities for FY2016 - FY2020.

[8] Alice Peck Day Memorial Hospital: Services. Available at https://www.alicepeckday.org/services. Accessed on March 9, 2023.

[9] Alice Peck Day Memorial Hospital, FY 2021 Community Benefit Report. Available at https://www.alicepeckday.org/sites/default/files/2022-12/FY21-Community-Benefits-Report-with-Addendum.pdf Accessed on March 8, 2023.

[10] Medicare Hospital Care Compare: Alice Peck Day Memorial Hospital. https://www.medicare.gov/care-compare/details/hospital/301305?id=21cd46eb-75a4-45e5-9a77-0826c1b61ea8&city=Claremont&state=NH&zipcode= . Accessed on March 17, 2023.

[11] Data retrieved from CMS Hospital Form 2552-10 Cost Reports for NH Acute Care Facilities for FY2016 - FY2020.

[12] New Hampshire Comprehensive Health Care Information System (NH CHIS).

[13] Medicare Hospital Care Compare: Alice Peck Day Memorial Hospital. https://www.medicare.gov/care-compare/details/hospital/301305?id=21cd46eb-75a4-45e5-9a77-0826c1b61ea8&city=Claremont&state=NH&zipcode= . Accessed on March 17, 2023.

[14] NH HealthCost: Valley Regional Hospital (2023). Available at https://nhhealthcost.nh.gov/provider/alice-peck-day-memorial-hospital/quality?carrier=uninsured. Accessed on March 3, 2023.

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Mt. Ascutney Hospital

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Table of Contents

Executive Summary

This report profiles Mt. Ascutney Hospital (MAH) on several dimensions as summarized and detailed below.

Overview

MAH is a 35-bed acute care facility located in Windsor, Vermont (VT). The hospital provides emergency care along with clinical specialties, including cardiology and pain management services, among other services.

Community Benefits

MAH's average yearly charity care costs for uninsured patients increased slightly but at a slower rate than the statewide average growth rate, according to a review of the U.S. Centers for Medicare & Medicaid Services (CMS) Hospital Cost Report (Form 2552-10) data for federal filing years* (FFYs) 2016-2020. The hospital did not report its charity care costs for insured patients.[1]

Financial Status

MAH's average operating margin for FFYs 2016-2020 was negative, but less negative than the Vermont state average. Its total margin was positive for all five years reviewed and exceeded the Vermont state average for four of those years. Revenues grew faster than expenses during this period; total expenses grew faster than the statewide rate while total revenue grew slightly lower than the statewide rate. The CMS Form 2552-10 data shows MAH's service volume declined slightly over the period reviewed at a pace faster than the statewide average, even while its inpatient discharges increased.[2]

Quality

Overall, patient experience at MAH was very positive. On the 10 CMS Hospital Care Compare patient experience scores, MAH scored better than the Vermont and national averages on eight measures and at or near the Vermont and national averages on two. Overall star rating takes into account mortality, safety of care, readmission, patient experience, and timely and effective care. MAH has an overall rating star rating of 4 out of 5 five stars.[3]

Contents of the Report

This report provides the following information about MAH:

- Service profile that includes general statistics, services offered, and a quality summary
- Multi-year profile of financial and utilization comparison statistics
- Patient experience survey ratings from CMS Hospital Care Compare

**Data for FFY 2016-2020 derived from each hospital's CMS 2552-10 Cost Report. Data are reported by each hospital's federal filing year. A hospital's federal filing year begins on the first day of the hospital's fiscal year on or after the beginning of the federal fiscal year (October 1). For example, federal 2020 data for Mt. Ascutney encompasses activity from Oct. 1, 2019, through Sept.30, 2020.*

Mt Ascutney Hospital Profile

General Hospital Information	
Type of Facility[4]	Acute Care
Total Licensed Beds[5]	25
Total Available Beds[5]	35
Bed Occupancy Rate[5]*	81.1%
Accredited by The Joint Commission	No
Annual Hospital Discharges	433[3]

Hospital Services Offered[6]	
• Cardiology Services • Diabetes and Nutrition Services • Emergency Medical Services	• Hospice Care • Oncology Services • Radiology Services

Quality Statistics Summary

The table below offers a view of MAH's performance on quality-of-care scores from two different sources: NH HealthCost and CMS Hospital Care Compare.

Source	*Measure***	*Score*
CMS Hospital Care Compare[7]	Quality of Care Measures Better Than Average	**8 out of 10**
	Quality of Care Measures Near Average	**2 out of 10**
	Quality of Care Measures Worse Than Average	**0 out of 10**
	Overall Rating***	**4 out of 5 stars**
	Patient Survey Rating******	**5 out of 5 stars**

**Bed occupancy rate is computed by dividing patient days by the number of total bed days available, both available within the S-3 Filing of the CMS 2552 Cost Report of each hospital.*

***Measures highlighted in shades of green are scores higher than the state or national average, and shades of yellow are scores at or near the state or national average.*

****This measure summarizes more than 100 measures of mortality, safety of care, readmission, patient experience, effectiveness of care, timeliness of care, and efficient use of medical imaging.*

*****This measure summarizes how patients recently discharged from the hospital responded to a survey about their hospital experience. The survey asked questions like how well a hospital's doctors and nurses communicated with the patient.*

******Rate of patients readmitted to the hospital within 30 days of discharge.*

Mt. Ascutney Hospital Financial and Utilization Statistics

The two tables below offer a multi-year financial comparison profile based on an analysis of CMS Hospital Cost Report (Form 2552-10) data for federal filing years (FFY) 2016-2020.* CMS requires hospitals to file financial data on these reports in a consistent format that produces a comparable set of measures. MAH's inpatient days declined over the period reviewed at a pace faster than the statewide rate, even while its inpatient discharges increased. Revenues grew slightly faster than expenses during this period; both grew faster than the statewide average growth rates for revenue and expenses. MAH's average yearly charity care costs for uninsured patients increased slightly but less than the statewide average growth rate. The hospital did not report charity care costs for insured patients. MAH's operating margins were better than break even from FFY 2016 – 2018 but dipped sharply in 2019. The hospital's average operating margin for the five-year period was negative, but less negative than the Vermont state average. Its total margin was positive for all five years reviewed and exceeded the Vermont state average for four of those years.[8] Trend values highlighted in green are better than the state average, those highlighted in yellow are the same, and those highlighted in red are worse.

Federal Filing Year*	2016	2017	2018	2019	2020	Average '16-'20 Annual Change	Statewide '16-'20 Average Annual Change
Total Hospital Discharges [S-3 Col 15 Ln 14] **	365	361	415	428	433	4.66%	0.27%
Total Hospital Days [S-3 Col 8 Ln 14]	7,179	7,115	7,140	7,189	6,453	-2.53%	-1.12%
Charity Care Costs (Uninsured Patients) [S-10 Col 1 Ln 23]	$262,583	$301,973	$348,040	$261,161	$282,654	1.91%	8.64%
Charity Care Costs (Insured Patients) [S-10 Col 2 Ln 23]	.	.	.	.	.	.	-1.54%
Total Unreimbursed and Uncompensated Care [S-10 Col 1 Ln 31]	$1,817,474	$1,289,427	$2,071,565	$2,015,056	$4,102,862	31.44%	8.71%
Total Operating Expenses [G-2 Col 2 Ln 43]	$49,585,014	$50,422,620	$53,449,229	$54,561,988	$55,812,070	3.14%	5.23%
Total Other Expenses [G-3 Ln 28]	.	.	.	.	.	.	98.24%
Total Expenses [Total Operating Expenses + Total Other Expenses]	$49,585,014	$50,422,620	$53,449,229	$54,561,988	$55,812,070	3.14%	0.00%
Total Inpatient Charges [C Pt 1 Col 6 Ln 202]	$24,144,564	$24,618,343	$26,712,213	$28,215,734	$28,023,314	4.02%	3.96%
Total Outpatient Charges [C Pt 1 Col 7 Ln 202]	$47,391,361	$48,598,922	$54,687,419	$58,732,077	$57,625,623	5.40%	1.64%
Net Patient Service Revenue [G-3 Ln 3]	$46,402,276	$48,253,025	$50,075,938	$44,221,861	$45,039,229	-0.73%	-0.98%
Net Income from Patient Services [G-3 Ln 5]	-$3,182,738	-$2,169,595	-$3,373,291	-$10,340,127	-$10,772,841	59.62%	65.40%
Other Income: Other [G-3 Ln 24.00]	$3,192,113	$3,553,789	$3,655,509	$3,630,799	$7,362,424	32.66%	78.48%

Total Other Hospital Income [G-3 Ln 25]	$4,942,844	$4,470,854	$5,575,296	$11,323,420	$17,010,424	61.04%	117.43%
Total Hospital Net Income [G-3 Ln 29]	$1,760,106	$2,301,259	$2,202,005	$983,293	$6,237,583	63.60%	-45.63%
Total Revenue [Net Patient Service Revenue + Total Other Hospital Income]	$51,345,120	$52,723,879	$55,651,234	$55,545,281	$62,049,653	5.21%	6.89%

Federal Filing Year*	2016	2017	2018	2019	2020	Average '16-'20 Margin	Statewide Average '16-'20 Margin
Operating Margin* **	0.02%	2.67%	0.53%	-14.02%	-6.51%	-3.46%	
Statewide Industry Average** **	-8.76%	-5.39%	-13.66%	-19.33%	-30.75%		-15.58%
Total Margin*** **	3.43%	4.36%	3.96%	1.77%	10.05%	4.71%	
Statewide Industry Average** **	-3.09%	4.99%	2.18%	0.98%	2.00%		1.41%

**Data included in this analysis only pertains to the hospitals themselves, not to any physician practices owned by the hospital or the hospital systems each facility is associated with. Data for 2016-2020 derived from each hospital's CMS 2552-10 Cost Report. Data are reported by each hospital's federal filing year. A hospital's federal filing year begins on the first day of the hospital's fiscal year on or after the beginning of the federal fiscal year (October 1). For example, federal 2020 data for Mt. Ascutney encompasses activity from Oct. 1, 2019 through Sept. 30, 2020.*

***Notations made in brackets "[ ]" reference the location in the 2552-10 worksheet where a specific figure derives from.*

****Operating Margin is calculated as {Net Patient Service Revenue plus Other Income (Other) less Total Operating Expenses less Total Other Expenses} divided by [Net Patient Service Revenue plus Other Income (Other)].*

*****The authors calculated a combined margin for all Vermont acute care hospitals using data reported on the CMS Hospital Form 2552-10 Cost Reports for Vermont acute care hospitals.*

******Total Margin is calculated as Total Hospital Net Income divided by {the sum of Net Patient Service Revenue plus Total Other Hospital Income}.*

Quality of Care at Mount Ascutney Hospital

The table below shows MAH's patient experience scores from CMS Hospital Care Compare, as of March 2023. The hospital patient survey, known as the Hospital Consumer Assessment of Healthcare Providers and Systems(HCAHPS), is a national survey instrument that is used to measure patient experiences at their respective hospitals. The results are a product of survey responses regarding the hospital experience of recently discharged patients. On the 10 CMS Hospital Care Compare patient experience scores, MAH scored better than the state and national averages on eight measures and at or near the state and national averages on two.[9]

Patient Experience

Measure Description*	Mt. Ascutney Hospital	VT Average	National Average
Patients who reported that their nurses "Always" communicated well	84%	83%	79%
Patients who reported that their doctors "Always" communicated well	87%	83%	80%
Patients who reported that they "Always" received help as soon as they wanted	75%	71%	66%
Patients who reported that staff "Always" explained about medicines before giving it to them	73%	66%	62%
Patients who reported that their room and bathroom were "Always" clean	87%	75%	72%
Patients who reported that the area around their room was "Always" quiet at night	62%	55%	62%
Patients who reported that YES; they were given information about what to do during their recovery at home	91 %	89%	86%
Patients who "Strongly Agree" they understood their care when they left the hospital	61%	56%	51%
Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)	83%	74%	71%
Patients who reported YES; they would definitely recommend the hospital	88%	73%	70%

**Measures highlighted in shades of green are scores higher than the state or national average and shades of yellow are scores at or near the state or national average.*

Citations

[1] Mt. Ascutney Hospital. 2021 Community Health Improvement Report. Available at https://www.mtascutneyhospital.org/sites/default/files/2022-06/community-health-benefits-report-2021.pdf. Accessed on March 9, 2023.

[2] Data retrieved from CMS Hospital Form 2552-10 Cost Reports for NH Acute Care Facilities for FY2016 - FY2020. Data are reported by each hospital's federal filing year. A hospital's federal filing year begins on the first day of the hospital's fiscal year on or after the beginning of the federal fiscal year (October 1). For example, federal 2020 data for Mt. Ascutney Hospital encompass activity from Oct. 1, 2019 through Sept. 30, 2020. Data included in this analysis only pertain to the hospitals themselves, not to any physician practices owned by the hospital or the hospital systems with which each facility is associated.

[3] Medicare Hospital Care Compare: Mt. Ascutney Hospital. https://www.medicare.gov/care-compare/details/hospital/471302?id=aa4de819-f8e5-4943-b842-a6e1b7dc4832&state=VT. Accessed on March 13, 2023.

[4] Mt. Ascutney Hospital: Quick Facts. Available at https://www.mtascutneyhospital.org/about/hospital-facts. Accessed on March 3, 2023.

[5] Data retrieved from CMS Hospital Form 2552-10 Cost Reports for NH Acute Care Facilities for FY2016 - FY2020. Bed occupancy rate calculation derived from CMS: https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/Accessing_Data_and_Sample_Computations.pdf.

[6] Mt. Ascutney: Department and Services. Available at https://www.mtascutneyhospital.org/health-services/departments-services. Accessed March 5, 2023.

[7] Medicare Hospital Care Compare: Mt. Ascutney Hospital.

[8] Data retrieved from CMS Hospital Form 2552-10 Cost Reports for NH Acute Care Facilities for FY2016 - FY2020.

[9] Medicare Hospital Care Compare: Mt. Ascutney Hospital.

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New London Hospital Profile

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May 2023

Table of Contents

Executive Summary

This report profiles New London Hospital (NLH) on several dimensions as summarized below and detailed in this report.

Overview

NLH is a 25-bed acute care facility located in New London, New Hampshire (NH). The hospital provides emergency care along with clinical specialties, including behavioral health and pain management services, among others.

Community Benefits

NLH provided over $6.1 million in community benefits, including and $430,000 in charity care in hospital fiscal year (HFY) 2019, and $2.6 million in other community benefit services, which include: community health improvement services and community benefits operations, health professionals education, subsidized health services, and in-kind contributions for community benefits, as noted in its FY 2020 Community Benefits Report.[1] NLH's Charity Care costs for uninsured patients increased significantly from federal filing year (FFY) 2016 through 2020 compared to the state average, based on a review of U.S. Centers for Medicare & Medicaid Services (CMS) Hospital Cost Report (Form 2552-10) data.[2]

Financial Status

NLH's operating and total margins were both consistently lower than the statewide average every year from FFY 2016 through FFY 2020. Its operating margin was negative in three of the five years reviewed, while its total margin was negative in two of the five years. NLH's inpatient service volume decreased during this period, while the statewide rate increased slightly over the same period. The authors based these findings on an analysis of CMS Form 2552-10 data for the hospital's FFY 2016-2020. CMS requires hospitals to file financial data on these reports in a consistent format that produces a comparable set of measures.[3]

Cost

NLH's outpatient prices were lower than the state average for some services and higher for others. NLH's payments from private insurers for emergency visits and office visits were generally lower than the state median payment, however NLH's payments from Anthem were higher than the state average. The hospital's payments from private insurers for radiology services were higher than the state median payment. The hospital did not bill for a sufficient volume of outpatient tests and procedures to assess its prices for these services; a physician group may bill for these services rather than the hospital. The estimated prices the hospital charged to uninsured patients were lower than the state median for emergency visits and office visits, but higher for radiology. The authors developed this assessment from an analysis of FY2022 Q2 data submitted to the New Hampshire Comprehensive Health Care Information System (CHIS).[4]

Quality

NLH's quality scores were variable. On the 10 CMS Hospital Care Compare patient experience scores, NLH scored better than the state and national averages on two measures, at or near the

state and national averages on five measures, and below the state and national averages on three measures. CMS Hospital Care Compare gave NLH an overall rating of 4 out of 5 stars.[5] On one additional quality measure reported on NH HealthCost, NLH scored better than average. [6]

Contents of this Report

This report provides the following information about NLH:

- Service profile that includes general statistics, services offered, cost of charity care and community benefits, and a summary of quality
- Multi-year comparison of financial and utilization statistics
- Pricing comparison of the average payment NLH receives for the outpatient services it provides compared to the state median payment for the same sets of services
- Outline of performance on health care quality and safety measures compiled by NH HealthCost
- Patient experience survey ratings from CMS Hospital Care Compare

New London Hospital Service Profile

General Hospital Information	
Type of Facility	Acute Care
Total Staffed Beds[7]	25
Total Available Beds[8]	25
Bed Occupancy Rate[5]*	56.2%
Accredited by The Joint Commission[5]	No
Annual Hospital Discharges[5]	780

Hospital Services Offered[9]

- Emergency services
- Behavioral health
- Dermatology services
- Diagnostic imaging and radiology
- Inpatient care
- Palliative care
- Pain management
- Surgery
- Urology
- Women's health

Charity Care and Other Community Benefits[10]

The table below offers a snapshot of the charity care and other community benefits provided to the greater New London community by NLH. All information derives from NLH's FY 2020 Community Benefit Report.

Unreimbursed Costs 2019	Benefits Provided	Financial Benefit
	(1) Financial Assistance and Means-Tested Government Programs	$3,492,432
	(2) Other Community Benefit Costs	$2,641,123
	Total Unreimbursed Community Benefit Expenses	**$6,133,555**

Quality Statistics Summary

The table below offers a view of NLH's performance on quality-of-care scores from two different sources: NH HealthCost and CMS Hospital Care Compare.

Source	*Measure***	*Score*
CMS Hospital Care Compare[11]	**Quality of Care Measures Better Than Average**	**2 out of 10**
	Quality of Care Measures Near Average	**5 out of 9**
	Quality of Care Measures Worse Than Average	**3 out of 9**
	Overall Rating***	**4 out of 5 stars**
	Patient Survey Rating******	**4 out of 5 stars**
	Unplanned readmission rating*********	No different than national rate

**Bed occupancy rate is computed by dividing patient days by the number of total bed days available, both available within the S-3 Filing of the CMS 2552 Cost Report of each hospital.*

***Measures highlighted in shades of green are scores higher than the state or national average, shades of yellow are scores at or near the state or national average, and shades of red are scores lower than the state or national average.*

****This measure summarizes more than 100 measures of mortality, safety of care, readmission, patient experience, effectiveness of care, timeliness of care, and efficient use of medical imaging.*

*****This measure summarizes how patients recently discharged from the hospital responded to a survey about their hospital experience. The survey asked questions like how well a hospital's doctors and nurses communicated with the patient.*

******Rate of patients readmitted to the hospital within 30 days of discharge.*

New London Hospital Financial and Utilization Statistics

The two tables below offer a multi-year financial comparison profile based on an analysis of CMS Form 2552-10 data for FFY 2016-2020.* CMS requires hospitals to file financial data on these reports in a consistent format that produces a comparable set of measures. NLH's inpatient service volume decreased during the period reviewed, while the statewide rate remained stable. Over the period reviewed, NLH's total expenses and revenues grew; only in FFY 2016 and FFY 2020 did NLH have a negative net income. NLH's expenses and total revenue grew at a slightly slower rate than the statewide average. NLH's charity care costs increased substantially and at a much higher rate than the statewide average for both insured and uninsured patients. NLH's operating and total margins were lower than the statewide average every year. The hospital's operating margin was negative in three of the five years reviewed. Its total margin was slightly negative in two of the five years.[12] Trend values highlighted in green are better than the state average and those highlighted in red are worse.

Federal Filing Year*	2016	2017	2018	2019	2020	Average '16-'20 Annual Change	Statewide '16-'20 Average Annual Change
Total Hospital Discharges [S-3 Col 15 Ln 14] **	1,019	809	759	717	780	-5.86%	-1.49%
Total Hospital Days [S-3 Col 8 Ln 14]	5,481	5,375	5,079	4,595	4,683	-3.64%	0.15%
Charity Care Costs (Uninsured Patients) [S-10 Col 1 Ln 23]	$250,036	$313,697	$608,480	$270,894	$424,711	17.46%	7.95%
Charity Care Costs (Insured Patients) [S-10 Col 2 Ln 23]	$326,936	$472,252	$614,471	$324,871	$1,186,899	65.76%	11.75%
Total Unreimbursed and Uncompensated Care [S-10 Col 1 Ln 31]	$1,899,923	$2,276,250	$2,121,604	$2,290,832	$2,237,299	4.44%	9.51%
Total Operating Expenses [G-2 Col 2 Ln 43]	$64,198,767	$65,171,914	$63,351,266	$66,816,588	$72,318,454	3.16%	5.52%
Total Other Expenses [G-3 Ln 28]	-$2,701,050	$304,001	$695,009	$89,476	$306,913	-27.84%	-16.72%
Total Expenses [Total Operating Expenses + Total Other Expenses]	$61,497,717	$65,475,915	$64,046,275	$66,906,064	$72,625,367	4.52%	-11.21%
Total Inpatient Charges [C Pt 1 Col 6 Ln 202]	$25,273,497	$23,467,818	$22,133,430	$18,839,063	$15,084,735	-10.08%	5.89%
Total Outpatient Charges [C Pt 1 Col 7 Ln 202]	$68,822,238	$72,057,355	$77,950,557	$70,421,899	$93,227,087	8.87%	8.12%
Net Patient Service Revenue [G-3 Ln 3]	$57,918,044	$58,932,342	$60,095,426	$53,942,990	$61,813,799	1.68%	2.72%
Net Income from Patient Services [G-3 Ln 5]	-$6,280,723	-$6,239,572	-$3,255,840	-$12,873,598	-$10,504,655	-16.81%	-245.10%
Other Income: Other [G-3 Ln 24.00]	$4,095,623	$4,407,601	$4,487,871	$4,339,498	$4,156,435	0.37%	27.13%
Total Other Hospital Income [G-3 Ln 25]	$3,547,106	$6,889,304	$6,444,196	$13,718,382	$10,396,858	48.28%	43.35%
Total Hospital Net Income [G-3 Ln 29]	-$32,567	$345,731	$2,493,347	$755,308	-$414,710	-293.35%	21.21%

Federal Filing Year*	2016	2017	2018	2019	2020	Average '16-'20 Annual Change	Statewide '16-'20 Average Annual Change
Total Revenue [Net Patient Service Revenue + Total Other Hospital Income]	$61,465,150	$65,821,646	$66,539,622	$67,661,372	$72,210,657	4.37%	5.89%

Federal Filing Year*	2016	2017	2018	2019	2020	Average '16-'20 Margin	Statewide Average '16-'20 Margin
Operating Margin* **	0.83%	-3.37%	0.83%	-14.80%	-10.09%	-5.32%	
Statewide Industry Average** **	3.00%	2.41%	3.32%	-0.55%	-0.39%		1.56%
Total Margin*** **	-0.05%	0.53%	3.75%	1.12%	-0.57%	0.95%	
Statewide Industry Average** **	6.13%	6.87%	6.03%	3.18%	9.17%		6.28%

**Data included in this analysis only pertain to the hospitals themselves, not to any physician practices owned by the hospital or the hospital systems each facility is associated with. Data for 2016-2020 are derived from each hospital's CMS 2552-10 Cost Report. Data are reported by each hospital's federal filing year. A hospital's federal filing year begins on the first day of the hospital's fiscal year on or after the beginning of the federal fiscal year (October 1). For example, federal 2020 data for New London encompass activity from July 1, 2020 through June 30, 2021.*

*** Notations made in brackets "[ ]" reference the location in the 2552-10 worksheet where a specific figure derives from.*

****Operating Margin is calculated as {Net Patient Service Revenue plus Other Income (Other) less Total Operating Expenses less Total Other Expenses} divided by [Net Patient Service Revenue plus Other Income (Other)].*

*****The authors calculated a combined margin for all New Hampshire acute care hospitals using data reported on the CMS Hospital Form 2552-10 Cost Reports for New Hampshire acute care hospitals.*

******Total Margin is calculated as Total Hospital Net Income divided by {the sum of Net Patient Service Revenue plus Total Other Hospital Income}.*

New London Hospital Estimated Outpatient Visit Pricing

The following chart shows the average payment NLH received for the services it provided in FY2022 Q2, compared to the state median payment for the same sets of services. The payments the hospital received from private insurers for emergency visits and office visits were generally lower than the state median payment, however the payments it received from Anthem were higher than the state average. The payments it received from private insurers for radiology services were higher than the state median payment. The hospital did not bill for a sufficient volume of outpatient tests and procedures to assess its prices for these services; a physician group may bill for these services rather than the hospital. The estimated price NLH charged to uninsured patients was lower than or close to the state median for all categories. Amounts highlighted in green are lower than the state median and amounts highlighted in red are higher than the state median.[13]

Event Type	New London Hospital			
	State Number of Events	*NLH Number of Events*	*Payments to NLH (weighted median)*	*Payments to NLH if NLH received the statewide median payment for its services*
Emergency Visits				
Anthem – NH	9,239	71	$365.63	$332.27
CIGNA	3,381	103	$383.61	$529.67
Harvard Pilgrim HC	5,489	96	$391.31	$484.90
Other Medical Insurance	2,414	13	N/A**-	$577.32
Uninsured*	20,523	283	$312.38	$367.54
Office Visits				
Anthem – NH	347,038	3376	$125.01	$171.87
CIGNA	88,211	1545	$126.94	$178.84
Harvard Pilgrim HC	208,442	2275	$106.74	$185.87
Other Medical Insurance	71,696	224	$103.19	$182.16
Uninsured*	715,394	7420	$116.10	$252.12
Outpatient Tests and Procedures				
Anthem – NH	15,031	4	N/A**	$2,044.76
CIGNA	4,060	-	N/A**	$1,190.28
Harvard Pilgrim HC	7,468	11	N/A**	$1,704.33
Other Medical Insurance	2,757	-	N/A**	$3,089.50
Uninsured*	31,059	42	N/A**	$2,405.91
Radiology Services				
Anthem – NH	61,083	166	$974.98	$412.10
CIGNA	17,079	321	$832.86	$590.65
Harvard Pilgrim HC	33,724	386	$1,010.66	$536.18
Other Medical Insurance	12,043	17	N/A**	$463.26
Uninsured*	129,855	1021	$859.83	$753.15

**NH HealthCost estimates the price to uninsured individuals based on the service mix for insured patients, and the hospital's charges less the discount the hospital offers to uninsured patients.*

***Weighted medians could not be calculated due to small sample size (fewer than 50 events)*

Source: Authors' analysis of NH CHIS Group Medical Plans and Uninsured Claims only, FY2022 Q2. Authors calculated the median payment by insurer by service for each hospital and median payment by insurer by service for the state as a whole. The chart shows the average of the median payment the hospital received for each service category, weighted by the hospital's service mix. The chart compares this amount to the average state median payment amount for each service weighted by the hospital's service mix.

Quality of Care at New London Hospital

The table below shows NLH's patient experience and quality of care scores from CMS Hospital Care Compare (first table) and NH HealthCost (next table) as of March 2023. The hospital patient survey, known as the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) is a national survey instrument that is used to measure patient experiences at their respective hospitals. The results are a product of survey responses regarding the hospital experience of recently discharged patients. On the 10 CMS Hospital Care Compare patient experiences scores, NLH scored above average on two of the hospital measures, around average on five of the measures, and below average on three of the measures.[14] On one additional quality measure reported on NH HealthCost, NLH scored better than average.[15]

Patient Experience

Measure Description	New London Hospital*	NH Average	National Average
Patients who reported that their nurses "Always" communicated well	80%	81%	79%
Patients who reported that their doctors "Always" communicated well	78%	79%	80%
Patients who reported that they "Always" received help as soon as they wanted	72%	65%	66%
Patients who reported that staff "Always" explained about medicines before giving it to them	57%	62%	62%
Patients who reported that their room and bathroom were "Always" clean	81%	73%	72%
Patients who reported that the area around their room was "Always" quiet at night	55%	54%	62%
Patients who reported that YES, they were given information about what to do during their recovery at home	82%	88%	86%
Patients who "Strongly Agree" they understood their care when they left the hospital+	46%	51%	51%
Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)	70%	70%	71%
Patients who reported YES, they would definitely recommend the hospital	71%	70%	71%

**Measures highlighted in shades of green are scores higher than the state or national average, shades of yellow are scores at or near the state or national average, and shades of red are lower than the state or national average.*

Timely Care

Time Spent in the Emergency Department Before Being Discharged	 ABOVE AVERAGE	144 min state average 159 min

Citations

[1] New London Hospital Community Benefits Report, 2020. Available at https://www.newlondonhospital.org/sites/default/files/2021-07/Community-Benefits-Form-2020.pdf . Accessed on March 3, 2023.

[2] Data retrieved from CMS Hospital Form 2552-10 Cost Reports for NH Acute Care Facilities for FY2016 - FY2020. Data are reported by each hospital's federal filing year. A hospital's federal filing year begins on the first day of the hospital's fiscal year on or after the beginning of the federal fiscal year (October 1). For example, federal 2020 data for New London encompass activity from July 1, 2020 through June 30, 2021. Data included in this analysis only pertain to the hospitals themselves, not to any physician practices owned by the hospital or the hospital systems with which each facility is associated.

[3] Data retrieved from CMS Hospital Form 2552-10 Cost Reports for NH Acute Care Facilities for FY2016 - FY2020.

[4] New Hampshire Comprehensive Health Care Information System (NH CHIS). NH CHIS Group Medical Plans and Uninsured Claims only, FY2020 Q2. Weighted average of median payment amounts compiled by the authors. Authors calculated the median payment by insurer by service for each hospital and median payment by insurer by service for the state as a whole. Data included in this analysis only pertain to the hospitals themselves, not to any physician practices owned by the hospital or the hospital systems with which each facility is associated.

[5] Medicare Hospital Care Compare: New London Hospital. https://www.medicare.gov/care-compare/details/hospital/301304?id=761b557f-08a3-4bc3-9969-7757806c8bb3&city=New%20London&state=NH&zipcode=#ProviderDetailsQualityIndicatorsContainer . Accessed on March 3, 2023.

[6] NH HealthCost: New London Hospital. Available at https://nhhealthcost.nh.gov/provider/new-london-hospital/quality?carrier=uninsured . Accessed on March 17, 2023.

[7] New London Hospital: About Us. Available at https://www.newlondonhospital.org/about/history#:~:text=Today%2C%20New%20London%20Hospital%20is,of%20quality%20service%20and%20caring. . Accessed on March 9, 2023.

[8] Data retrieved from CMS Hospital Form 2552-10 Cost Reports for NH Acute Care Facilities for FY2016 - FY2020. Bed occupancy rate calculation derived from CMS: https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/Accessing_Data_and_Sample_Computations.pdf.

[9] New London Hospital: Services at New London Hospital. Available at https://www.newlondonhospital.org/services/. Accessed on March 13, 2023.

[10] New London Hospital Community Benefits Report, 2020. Available at https://www.newlondonhospital.org/sites/default/files/2021-07/Community-Benefits-Form-2020.pdf . Accessed on March 3, 2023.

[11] Medicare Hospital Care Compare: New London Hospital. https://www.medicare.gov/care-compare/details/hospital/301304?id=761b557f-08a3-4bc3-9969-7757806c8bb3&city=New%20London&state=NH&zipcode=#ProviderDetailsQualityIndicatorsContainer . Accessed on March 3, 2023.

[12] Data retrieved from CMS Hospital Form 2552-10 Cost Reports for NH Acute Care Facilities for FY2016 - FY2020.

[13] New Hampshire Comprehensive Health Care Information System (NH CHIS).

[14] Medicare Hospital Care Compare: New London Hospital. https://www.medicare.gov/care-compare/details/hospital/301304?id=761b557f-08a3-4bc3-9969-7757806c8bb3&city=New%20London&state=NH&zipcode=#ProviderDetailsQualityIndicatorsContainer . Accessed on March 3, 2023.

[15] NH HealthCost: New London Hospital. Available at https://nhhealthcost.nh.gov/provider/new-london-hospital/quality?carrier=uninsured . Accessed on March 17, 2023.

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Valley Regional Hospital Profile

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Table of Contents

Executive Summary

This report profiles Valley Regional Hospital (VRH) on several dimensions, as summarized and detailed below.

Overview

VRH is a 25-bed acute care facility located in Claremont, New Hampshire (NH). The hospital provides emergency care and clinical specialty services, including behavioral health, heart and vascular services, oncology, and pain management care, among others.

Community Benefits

VRH provided $1.2 million in charity care and community building activities and $139,192 in other community benefit services, which include: community health improvement services and community benefits operations, health professionals' education, subsidized health services, health research, and in-kind contributions for community benefits, as noted in its FY 2020 Community Benefits Report. A review of U.S. Centers for Medicare & Medicaid Services (CMS) Hospital Cost Report (Form 2552-10) data for federal filing years* (FFYs) 2016-2020 showed the hospital's charity care costs for uninsured patients decreased at a much faster rate than the statewide rate, while its charity care costs for insured patients increased at more than double the state rate.[1]

Financial Status

VRH's service volume increased across FFYs 2016-2020 and was higher than the statewide growth rate over the same period. The hospital reported a slow increase in expenses during these years, in contrast to the negative expense growth for the statewide average. The hospital's operating margins were negative and lower than the statewide average for each year between FFY 2016 and 2020, except for 2019. Its total margins were positive for FFYs 2018-2020 but lower than statewide averages for all years reviewed. The authors based these findings on an analysis of CMS Hospital Cost Report (Form 2552-10) data for the hospital's FFYs 2016-2020.* CMS requires hospitals to file financial data on these reports annually in a consistent format that produces a comparable set of measures.[2]

Cost

The payments VRH received from private insurers for office visits were lower than the state median price. However, VRH received higher payments from Anthem for emergency services, and the hospital received higher payments for radiology services from all private insurers. The hospital did not bill for a sufficient volume of outpatient tests and procedures to assess its prices for these services. The estimated price the hospital charged to uninsured patients was lower than the state median for emergency services and office visits, but higher for outpatient tests and procedures and radiology. The authors developed this assessment from an analysis of FY2022 Q2 data submitted to the NH Comprehensive Health Care Information System (CHIS).[3]

Data for 2016-2020 derived from each hospital's CMS 2552-10 Cost Report. Data are reported by each hospital's federal filing year. A hospital's federal filing year begins on the first day of the hospital's fiscal year on or after the beginning of the federal fiscal year (October 1). For example, federal 2019 data for Huggins encompass activity from October 1, 2019 through September 30, 2020.

Quality of Care

VRH's quality scores were variable. CMS Hospital Care Compare gave VHR a positive overall rating star rating of 4 out of 5 five stars for the year ending March 2022. This overall star rating encompasses mortality, safety of care, readmission, patient experience, and timely and effective care measures. On 10 CMS Hospital Care Compare patient experience scores, VRH scored better than the state and national averages on two measures, at or near the state and national averages on five measures, and below average on three measures. On the other quality measure reported on NH HealthCost, VRH scored better than the average on one measure.[4]

Population Health

On numerous population health measures, Sullivan County performed similar to or better than the state average. However, the county does have ongoing health challenges to address, including the following:

-
- Higher ratio of population compared to primary care physicians
- Higher ratio of population compared to mental health professionals
- Higher ratios of population compared to dental health providers

Community Health Priorities

The VRH Community Health Needs Assessment highlighted community members' concerns regarding health priorities. The section entitled *Input on Health Issues and Priorities* reported responses to a survey that asked community members to select the most pressing health issues out of a list of 27 potential topics. The Needs Assessment reported these top five health concerns:

1. Ability to get mental health services (52% of responses)
2. Cost of health care services (46% of responses)
3. Cost of health insurance (43% of responses)
4. Cost of prescription drugs (37% of responses)
5. Misuse and addiction to drugs and alcohol (33%)

In its 2021 Community Health Needs Assessment,[5] VRH identified the following priority health needs of the community:

1. Availability of mental health services
2. Cost of healthcare services and affordability of health insurance
3. Alcohol and drug use prevention, treatment and recovery
4. Socio-economic conditions affecting health and well-being, such as housing affordability, access to healthy foods, and affordable childcare
5. Affordability and availability of dental care services
6. Prevention of child abuse and neglect

Contents of this Report

This report provides the following information about VRH:

- Service profile that includes general statistics, services offered, cost of charity care and community benefits, and summary of quality
- Multi-year profile of financial and utilization comparison statistics
- Pricing comparison of the average payment VRH receives for outpatient services it provides compared to the state median payment for the same sets of services
- Outline of performance on health care quality and safety measures compiled by NH HealthCost
- Patient experience survey ratings questions from CMS Hospital Care Compare
- Map of the communities identified by VRH its service area
- Medicaid enrollment for towns that comprise VRH's primary service area
- Comparison profile of population health measures for Claremont, Sullivan County, NH, and the United States

Valley Regional Hospital Service Profile

General Hospital Information	
Type of Facility	Short-Term Acute Care
Total Staffed Beds[6]	21
Total Available Beds[7]	25
Bed Occupancy Rate*[7]	40.8%
Accredited by The Joint Commission	No
Annual Hospital Discharges[7]	499

Hospital Services Offered [8]

- Emergency Services
- Specialty Care
- Cancer Care and Infusion Services
- Inpatient Care
- Primary Care
- Rehabilitation Services
- Outpatient Services
- Medical Imaging/ Radiology
- Audiology

Charity Care and Other Community Benefits[9]

The table below offers a snapshot of the charity care and other community benefits provided to the greater Sullivan County community by VRH. All information derives from the hospital's FY 2020 Community Benefit Report.

Unreimbursed Costs 2021	Benefits Provided	Financial Benefit
	(1) Financial Assistance and Means-Tested Government Programs	$ 2,294,942
	(2) Other Community Benefits Cost	$ 139,192
	(3) Community Building Activities	$ 125,434
	Total Unreimbursed Community Benefit Expenses	**$ 2,559,568**

Quality Statistics Summary

The table below offers a view of VRH's performance on quality-of-care scores from CMS Hospital Care Compare.

Source	*Measure***	*Score*

CMS Hospital Care Compare[10]	**Quality of Care Measures Better Than Average**	**2 out of 10**
	Quality of Care Measures Near Average	**5 out of 10**
	Quality of Care Measures Worse Than Average	**3 out of 10**
	Overall Rating* **	**4 out of 5 stars**
	Patient Survey Rating** **	**N/A**
	Unplanned readmission rating*****	No different than national rate

**Bed occupancy rate is computed by dividing patient days by the number of total bed days available; both are available within the S-3 Filing of each hospital's CMS 2552 Cost Report.*

***Measures highlighted in shades of green are scores higher than the state or national average, shades of yellow are scores at or near the state or national average, and shades of red are scores lower than the state or national average.*

****This measure summarizes more than 100 measures of mortality, safety of care, readmission, patient experience, effectiveness of care, timeliness of care, and efficient use of medical imaging.*

*****This measure summarizes how patients recently discharged from the hospital responded to a survey about their hospital experience. The survey asked questions like how well a hospital's doctors and nurses communicated with the patient.*

******Rate of patients readmitted to the hospital within 30 days of discharge.*

Valley Regional Hospital Financial and Utilization Statistics

The two tables below offer a multi-year financial comparison profile based on an analysis of CMS Hospital Cost Report (Form 2552-10) data for the hospital's federal filing years (FFY) 2016-2020.[11*] CMS requires hospitals to file financial data on these reports in a consistent format that produces a comparable set of measures. VRH's inpatient service volume increased during the period reviewed, which contrasts with the stable statewide growth rate over the same period. The hospital reported a slow increase in expenses from FFY 2016-2020 despite a statewide average decline over the same period. VRH's revenue increased at a slightly higher rate than the statewide rate during the same period. VRH's charity care costs for uninsured patients increased at a significantly faster rate than the statewide rate over the period reviewed; its charity care costs for insured patients increased slightly more than the state rate. Between FFY 2016 and 2020, VRH's operating margins were negative and lower than the statewide average every year except for 2019. Its total margins were lower than the statewide average for all years. In the table below, trend values highlighted in green are better than the state average, and those highlighted in red are worse.

Federal Filing Year*	2016	2017	2018	2019	2020	Average '16-'20 Annual Change	Statewide '16-'20 Average Annual Change
Total Hospital Discharges [S-3 Col 15 Ln 14] **	451	568	523	501	499	2.66%	-1.49%
Total Hospital Days [S-3 Col 8 Ln 14]	3,062	2,994	3,403	3,667	3,618	4.54%	0.15%
Charity Care Costs (Uninsured Patients) [S-10 Col 1 Ln 23]	$275,691	$221,945	$780,385	$774,222	$762,647	44.16%	7.95%
Charity Care Costs (Insured Patients) [S-10 Col 2 Ln 23]	$439,946	$1,076,671	$531,674	$462,869	$690,073	14.21%	11.75%
Total Unreimbursed and Uncompensated Care [S-10 Col 1 Ln 31]	$3,826,836	$2,936,472	$3,450,918	$3,842,867	$5,177,817	8.83%	9.51%
Total Operating Expenses [G-2 Col 2 Ln 43]	$43,117,357	$44,126,792	$46,377,434	$47,693,570	$46,670,728	2.06%	5.52%
Total Other Expenses [G-3 Ln 28]	$3,551	.	$148,945	$12,395	.	.	-16.72%
Total Expenses [Total Operating Expenses + Total Other Expenses]	$43,120,908	$44,126,792	$46,526,379	$47,705,965	$46,670,728	2.06%	-11.21%
Total Inpatient Charges [C Pt 1 Col 6 Ln 202]	$6,540,862	$7,617,599	$8,163,578	$8,427,050	$8,871,659	8.91%	5.89%
Total Outpatient Charges [C Pt 1 Col 7 Ln 202]	$42,964,881	$44,885,958	$52,656,773	$56,132,961	$52,007,126	5.26%	8.12%
Net Patient Service Revenue [G-3 Ln 3]	$37,738,617	$39,558,415	$44,569,312	$46,094,933	$41,817,348	2.70%	2.72%
Net Income from Patient Services [G-3 Ln 5]	-$5,378,740	-$4,568,377	-$1,808,122	-$1,598,637	-$4,853,380	-2.44%	-245.10%

Other Income: Other [G-3 Ln 24.00]	$1,112,799	$1,442,689	$1,367,576	$1,981,513	$1,443,293	7.42%	27.13%
Total Other Hospital Income [G-3 Ln 25]	$1,830,324	$3,882,531	$2,733,314	$2,457,387	$7,872,794	82.53%	43.35%
Total Hospital Net Income [G-3 Ln 29]	-$3,551,967	-$685,846	$776,247	$846,355	$3,019,414	-46.25%	21.21%
Total Revenue [Net Patient Service Revenue + Total Other Hospital Income]	$39,568,941	$43,440,946	$47,302,626	$48,552,320	$49,690,142	6.39%	5.89%

Federal Filing Year*	2016	2017	2018	2019	2020	Average '16-'20 Margin	Statewide Average '16-'20 Margin
Operating Margin* **	-10.99%	-7.62%	-1.28%	0.77%	-7.88%	-5.40%	
Statewide Industry Average** **	3.00%	2.41%	3.32%	-0.55%	-0.39%		1.56%
Total Margin*** **	-8.98%	-1.58%	1.64%	1.74%	6.08%	-0.22%	
Statewide Industry Average** **	6.13%	6.87%	6.03%	3.18%	9.17%		6.28%

**Data included in this analysis only pertain to the hospitals themselves, not to any physician practices owned by the hospital or the hospital systems each facility is associated with. Data for FFYs 2016-2020 are derived from each hospital's CMS 2552-10 Cost Report. Data are reported by each hospital's federal filing year. A hospital's federal filing year begins on the first day of the hospital's fiscal year on or after the beginning of the federal fiscal year (October 1). For example, federal 2020 data for Huggins encompass activity from October 1, 2020, through September 30, 2021.*

***Notations in brackets "[ ]" reference the 2552-10 worksheet data source.*

****Operating Margin is calculated as {Net Patient Service Revenue plus Other Income (Other) less Total Operating Expenses less Total Other Expenses} divided by [Net Patient Service Revenue plus Other Income (Other)].*

*****The authors calculated a combined margin for all New Hampshire acute care hospitals using data reported on the CMS Hospital Form 2552-10 Cost Reports for New Hampshire acute care hospitals.*

******Total Margin is calculated as Total Hospital Net Income divided by {the sum of Net Patient Service Revenue plus Total Other Hospital Income}.*

Valley Regional Hospital Estimated Outpatient Visit Pricing

The following chart shows the average payment VRH received for the services it provided in FY2022 Q2, compared to the state median payment for the same sets of services. The hospital's payments from private insurers for emergency and office visits were lower than the state median price, except for the payments it received from Anthem for emergency visits. In comparison, VRH received higher payments radiology services from all private insurers. In addition, the hospital received higher payments from Anthem for two of the four service categories. The hospital did not bill for a sufficient volume of outpatient tests and procedures to assess its prices for these services; a physician group may bill for these services rather than the hospital. The estimated price VRH charged to uninsured patients was lower than the state median for emergency and office visits but higher for outpatient tests and procedures, and radiology services. Amounts highlighted in green are lower than the state median and amounts highlighted in red are higher than the state median. The authors developed this assessment from an analysis of FY2022 Q2 data submitted to the NH Comprehensive Health Care Information System (CHIS).[12]

Event Type	Valley Regional Hospital			
	State Number of Events	*VRH Number of Events*	*Payments to VRH (weighted median)*	*Payments to VRH if VRH received the statewide median payment for its services*
Emergency Visits				
Anthem – NH	9,239	266	$446.74	$332.27
CIGNA	3,381	154	$456.72	$529.67
Harvard Pilgrim HC	5,489	117	$447.33	$484.90
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Uninsured*	20,523	547	$315.06	$367.54
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Harvard Pilgrim HC	208,442	1037	$116.85	$185.87
Other Medical Insurance	71,696	84	$115.37	$182.16
Uninsured*	715,394	3620	$92.39	$252.12
Outpatient Tests and Procedures				
Anthem – NH	15,031	26	NA**	$2,044.76
CIGNA	4,060	10	NA**	$1,190.28
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Other Medical Insurance	2,757	-	-	$3,089.50
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Radiology Services				
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** NH HealthCost estimates the prices a hospital offers to uninsured individuals based on the prices paid by private insurers and the hospital's discount policy for uninsured patients.*

***Weighted medians could not be calculated due to the small sample size (fewer than 50 events).*

Source: Authors' analysis of NH CHIS Group Medical Plans and Uninsured Claims only, FY2022 Q2. Authors calculated the median payment by insurer by service for each hospital and the median payment by insurer by service for the state as a whole. The chart shows the hospital's average median payment for each service category, weighted by the hospital's service mix. The chart compares this amount to the average state median payment amount for each service weighted by the hospital's service mix.

Quality of Care

The tables below show VRH's patient experience and quality of care scores from CMS Care Hospital Compare[13] (first table) and NH HealthCost[14] (second table). The hospital patient survey, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), is a national survey instrument used to measure patient experiences at their respective hospitals. The results are a product of survey responses regarding the hospital experience of recently discharged patients for the year ending March 2022. On the 10 CMS Hospital Care Compare patient experience scores, VRH scored better than the state and national averages on two patient measures, at or near the state and national averages on five measures, and below the state and national averages on three measures.

In addition, NH HealthCost reports one measure in the “Timely Care” category for VRH. "Time Spent in the Emergency Department Before Being Discharged" is 180 minutes at VRH, compared to the state average of 159 minutes. The hospital did not have sufficient volume to support the calculation of additional quality measures.

Patient Experience

Measure Description*	Valley Regional Hospital**	NH Average	National Average
Patients who reported that their nurses "Always" communicated well	76%	81%	79%
Patients who reported that their doctors "Always" communicated well	75%	79%	80%
Patients who reported that they "Always" received help as soon as they wanted	73%	65%	66%
Patients who reported that staff "Always" explained about medicines before giving it to them	55%	62%	62%
Patients who reported that their room and bathroom were "Always" clean	68%	73%	72%
Patients who reported that the area around their room was "Always" quiet at night	68%	54%	62%
Patients who reported that YES, they were given information about what to do during their recovery at home	84%	88%	86%
Patients who "Strongly Agree" they understood their care when they left the hospital	50%	51%	51%
Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)	63%	70%	71%
Patients who reported YES, they would definitely recommend	62%	71%	70%

** Measures highlighted in shades of green are scores higher than the state or national average, shades of yellow are scores at or near the state or national average, and shades of red are scores lower than the state or national average.*

***Fewer than 100 patients completed the HCAHPS survey. Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance.*

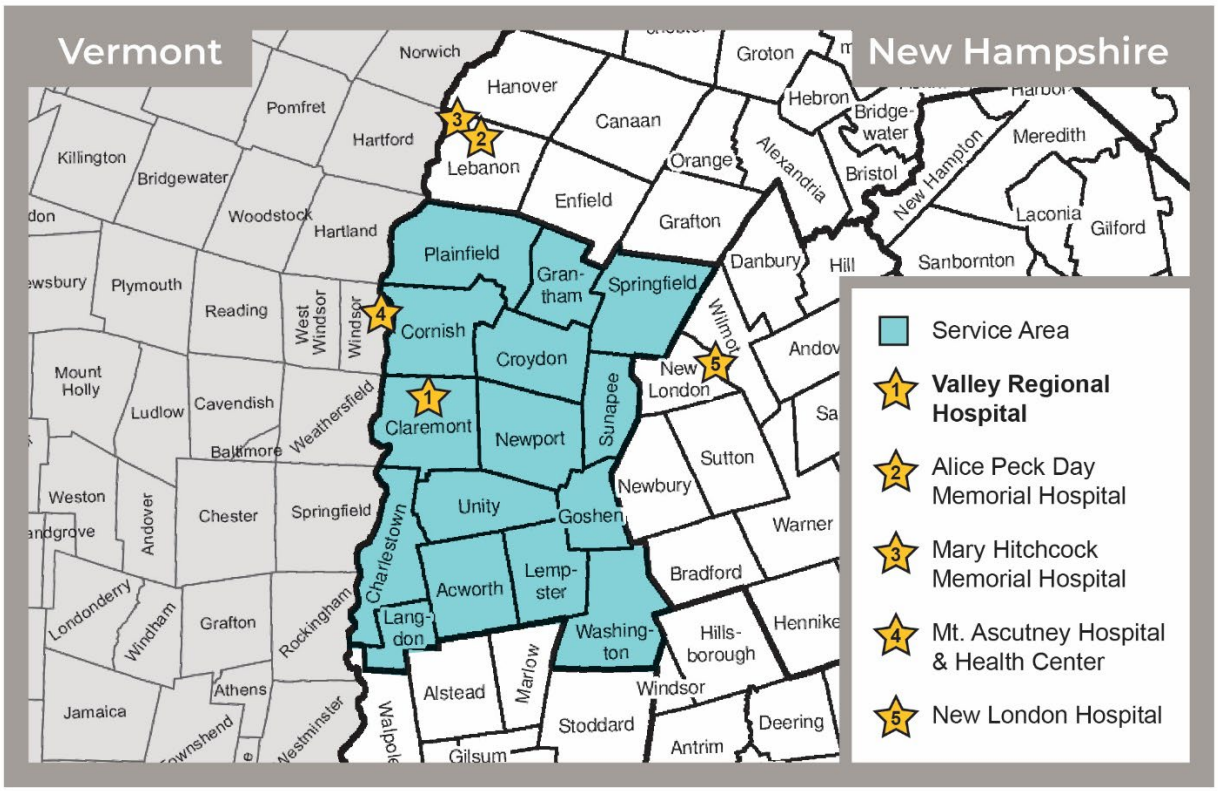
Timely Care

Time Spent in the Emergency Department Before Being Discharged	 LONGER THAN AVERAGE	180 min state average 159min

Communities Served by Valley Regional Hospital

The following map shows the communities VRH identifies as its service area, as listed in its 2021 Community Health Needs Assessment.[15] The communities the hospital serves span over 15 cities in Sullivan County. VRH conducted a needs assessment for these communities, which are shaded in blue on the map below. The stars show the locations of VRH, together with the nearby D-HH affiliated hospitals.

Note: this map is based on communities reported by the hospital; it is not based on an anti-trust analysis.



Medicaid Enrollment

The following table shows Medicaid enrollment in the towns that make up VRH's primary service area, as defined in its 2021 Community Health Needs Assessment, as well as statistics for NH and the United States. As of February 2023, the Medicaid enrollment rate in NH was 18%, and in the United States, the rate was 27%. Claremont and Newport's Medicaid enrollment rates exceeded the national average. Charlestown, Croyden, Goshen, Lempster, and Washington's Medicaid enrollment rates exceeded the state average but were lower than the national average Medicaid enrollment rate. All other towns in VRH's primary service area have Medicaid enrollment rates below the state and national average.

City/Town[16]	Service Area	County	Total Population[16]	Medicaid Enrollment[17]	% of Population enrolled in Medicaid*
Acworth	Primary	Sullivan	862	139	**16%**
Charlestown	Primary	Sullivan	4,868	1,246	**26%**
Claremont	Primary	Sullivan	13,031	4,767	**37%**
Cornish	Primary	Sullivan	1,631	158	**10%**
Croydon	Primary	Sullivan	817	155	**19%**
Goshen	Primary	Sullivan	802	168	**21%**
Grantham	Primary	Sullivan	3,437	251	**7%**
Langdon	Primary	Sullivan	658	84	**13%**
Lempster	Primary	Sullivan	1,143	250	**22%**
Newport	Primary	Sullivan	6,364	2,030	**32%**
Plainfield	Primary	Sullivan	2,495	193	**8%**
Springfield	Primary	Sullivan	1,283	126	**10%**
Sunapee	Primary	Sullivan	3,378	426	**13%**
Unity	Primary	Sullivan	1,510	157	**10%**
Washington	Primary	Sullivan	1,209	244	**20%**
New Hampshire			1,388,779	250,478	**18%**
United States (2022)			334,229,745[18]	91,786,257[19]	**27%**

**Author's calculation of Medicaid enrollment by Total Population.*

Profile Comparison of City, County, State, and Country Population Health Data

The table below offers a community health profile compiled from multiple sources. Numbers in the Source column refer to citations in the endnotes. "NA" indicates that the measure was unavailable for the geographic area. "Z" indicates that the unit's value is greater than zero but less than half a unit of measure shown. Yellow highlighting indicates that the local area scores worse on the measure than the state or the country as a whole.[20]

Measure	Claremont City	Sullivan County	New Hampshire	United States	Source
Population					
Population estimates, July 1, 2021, (V2021)	13,039	13,039	1,388,992	331,893,745	18
Population estimates base, April 1, 2020, (V2021)	12,940	43,063	1,377,529	331,449,281	18
Population, percent change - April 1, 2020 (estimates base) to July 1, 2021 (V2021)	0.8%	1.1%	0.8%	0.1%	18
Population, Census, April 1, 2010	109,565	400,721	1,316,470	308,745,538	18
Population, Census, April 1, 2020	12,949	43,063	1,377,529	331,449,281	18
Age and Sex					
Persons under 5 years, percent	6.4%	4.3%	4.5%	5.7%	18
Persons under 18 years, percent	18.2%	17.9%	18.5%	22.2%	18
Persons 65 years and over, percent	19.8%	23.0%	19.3%	16.8%	18
Female persons, percent	52.2%	50.0%	50.1%	50.5%	18
Race and Hispanic Origin					
White alone, percent	96.7%	95.8%	92.8%	75.8%	18

Measure	Claremont City	Sullivan County	New Hampshire	United States	Source
Black or African American alone, percent	1.0%	0.8%	1.9%	13.6%	18
American Indian and Alaska Native alone, percent	0.0%	0.4%	0.3%	1.3%	18
Asian alone, percent	0.4%	1.1%	3.1%	6.1%	18
Native Hawaiian and Other Pacific Islander alone, percent	0.0%	--	0.1%	0.3%	18
Two or More Races, percent	2.0%	1.9%	1.8%	2.9%	18
Hispanic or Latino, percent	2.7%	2.0%	4.4%	18.9%	18
White alone, not Hispanic or Latino, percent	93.9%	94.1%	89.1%	59.3%	18
Families & Living Arrangements					
Households, 2016-2020	5,453	17,281	539,116	122,354,219	18
Persons per household, 2016-2020	2.36	2.46	2.44	2.60	18
Living in same house 1 year ago, percent of persons age 1 year+, 2016-2020	85.6%	88.9%	86.4%	86.2%	18
Language other than English spoken at home, percent of persons age 5 years+, 2016-2020	5.8%	3.6%	8.1%	21.5%	18
Education					
High school graduate or higher, percent of persons age 25 years+, 2015-2019	87.2%	91.1%	93.3%	88.5%	18

Measure	Claremont City	Sullivan County	New Hampshire	United States	Source
Bachelor's degree or higher, percent of persons age 25 years+, 2015-2019	21.2%	29.6.%	37.6%	32.9%	18
Health					
Persons with a disability, under age 65 years, percent, 2016-2020	13.8%	9.8%	8.9%	8.7%	18
Persons without health insurance, under age 65 years, percent	7.9%	8.6%	6.2%	9.8%	18
Percent of adults who currently have asthma, ages 18 and older	N/A	N/A	13.2%	8.4%	21
Percent of adults with asthma with persistent severity	NA	NA	NA	40.4%	22
Number of ED visits due to asthma per 100,000 adults	NA	N/A	4,000 emergency room visits total	104[22]	23
Percent of adults who have diabetes, ages 18 and older	N/A	8.2%	7.5%	8.5%	24,25
Number of diabetes-related hospitalizations per 100,000 adults	N/A	N/A	2,931.7	3,370.0	20, 26
Number of drug-related deaths per 100,000 people	N/A	13.6[21]	21.8	106.0	27, 28
Number of drug-related ED visits per 100,000 people	NA	NA	181.7	149.0	27, 29
Number of deaths among residents under	NA	NA	426.9	423.0	30

Measure	Claremont City	Sullivan County	New Hampshire	United States	Source
age 75 per 100,000 (age-adjusted)					
Number of deaths among children under age 18 per 100,000	NA	NA	37.3	51.8	30
Number of all infant deaths (within 1 year) per 100,000 live births	NA	NA	441.0	543.6	30, 31
Percentage of adults reporting 14 or more days of poor physical health per month	N/A	N/A	12%	13%	20
Percentage of adults reporting 14 or more days of poor mental health per month	13%	13%	12%	NA	20
Number of persons living with a diagnosis of human immunodeficiency virus (HIV) infection per 100,000 people	N/A	127.0	107.0	374.6	20, 32
Health Behaviors					
Percentage of adults who are current smokers	N/A	19%	17%	16%	20
Percentage of adults that report a BMI of 30 or more	N/A	NA	32%	32%	20
Food environment index [0 (worst) to 10 (best)]	NA	8.6	8.8	NA	20
Percentage of adults age 20 and over reporting no leisure-time physical activity	N/A	24%	21%	26%	20
Percentage of population with	N/A	92%	74%	80%	20

Measure	Claremont City	Sullivan County	New Hampshire	United States	Source
adequate access to locations for physical activity					
Percentage of adults reporting binge or heavy drinking	N/A	19%	22%	21%	20
Percentage of driving deaths with alcohol involvement	N/A	34%	33%	27%	20
Number of newly diagnosed chlamydia cases per 100,000 people	NA	236.4	263.1	551.0	20
Number of births per 1,000 female population ages 15-19	NA	16	9	19	20
Percentage of population who lack adequate access to food	NA	8%	9%	8%	20
Percentage of population who are low-income and do not live close to a grocery store	NA	6.%	5%	6%	20
Number of motor vehicle crash deaths per 100,000 population	NA	14.0	33.0	27.2	20
Percentage of adults who report fewer than 7 hours of sleep on average	NA	32%	35%	35%	20
Clinical Care					
Ratio of population to primary care physicians	NA	1,390:1	1,110:1	1,310:1	20
Ratio of population to dentists	NA	2,550:1	1,300:1	1,400:1	20

Measure	Claremont City	Sullivan County	New Hampshire	United States	Source
Ratio of population to mental health providers	NA	500:1	290:1	350:1	20
Number of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees	NA	3,503	3,436	3,767	20
Percentage of female Medicare enrollees ages 65-74 that receive mammography screening	NA	51%	49%	43%	20
Quality of Life					
Years of potential life lost before age 75 per 100,000 population (age-adjusted)	NA	330.0	310.0	360.6	20
Percentage of adults reporting fair or poor health (age-adjusted)	NA	16%	14%	18%	20
Percentage of live births with low birth weight (< 2500 grams)	NA	7%	7%	8%	20
Income & Poverty					
Median household income (in 2020 dollars), 2016-2020	$46,848	$63,760	$77,923	$64,994	18
Per capita income in past 12 months (in 2020 dollars), 2016-2020	$26,158	$33,207	$41,234	$35,384	18
Persons in poverty, percent	16%	9%	7%	12%	18
Geography					
Population per square mile, 2020	300.1	80.1	153.9	93.8	18

Measure	Claremont City	Sullivan County	New Hampshire	United States	Source
Land area in square miles, 2020	43	538	8,954	3,533,038	18
Physical Environment					
Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)	NA	6.1	5.7	7.5	20

Citations

[1] Valley Regional Hospital Community Benefit Report, 2020. Available at https://vrh.org/wp-content/uploads/2022/03/community-benefits-report-2022.pdf. Accessed on March 1, 2023

[2] Data retrieved from CMS Hospital Form 2552-10 Cost Reports for NH Acute Care Facilities for FY2016 - FY2020. Data are reported by each hospital's federal filing year. A hospital's federal filing year begins on the first day of the hospital's fiscal year on or after the beginning of the federal fiscal year (October 1). For example, federal filing year 2020 data for Valley Regional Hospital encompass activity from October 1, 2019 through September 30, 2020. Data included in this analysis only pertain to the hospitals themselves, not to any physician practices owned by the hospital or the hospital systems with which each facility is associated.

[3] New Hampshire Comprehensive Health Care Information System (NH CHIS). NH CHIS Group Medical Plans and Uninsured Claims only, FY2020 Q2. Weighted average of median payment amounts compiled by the authors. Authors calculated the median payment by insurer by service for each hospital and median payment by insurer by service for the state as a whole.

[4] Medicare Hospital Care Compare: Valley Regional Hospital. Available at https://www.medicare.gov/care-compare/details/hospital/301308?city=Claremont&state=NH&zipcode=&measure=hospital-patient-surveys#ProviderDetailsQualityIndicatorsContainer. Accessed on March 2, 2023.

[5] Valley Regional Healthcare, Community Needs Assessment 2021. Available at: https://vrh.org/wp-content/uploads/2021/09/2021-Valley-Regional-Hospital-Community-Health-Needs-Assessment-final-1-min.pdf. Accessed on April 7, 2023.

[6] New Hampshire Charitable Trusts Foundation. (2023). Valley Regional Hospital. Available at https://www.doj.nh.gov/charitable-trusts/valley-regional-dartmouth-health.htm. https://www.ahd.com/free_profile/301308/Valley_Regional_Hospital/Claremont/New_Hampshire/. Accessed on March 10, 2023.

[7] Data retrieved from CMS Hospital Form 2552-10 Cost Reports for NH Acute Care Facilities for FY2020. Bed occupancy rate calculation is derived from CMS: https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/downloads/Accessing_Data_and_Sample_Computations.pdf.

[8] Valley Regional Hospital: Services. Available at https://vrh.org/our-services/. Accessed on March 2, 2023.

[9] Valley Regional Hospital Community Benefit Report, 2020. Available at https://vrh.org/wp-content/uploads/2022/03/community-benefits-report-2022.pdf. Accessed on March 1, 2023.

[10] Medicare Hospital Care Compare: Valley Regional Hospital.

[11] Data retrieved from CMS Hospital Form 2552-10 Cost Reports for NH Acute Care Facilities for FY2016 - FY2020.

[12] New Hampshire Comprehensive Health Care Information System (NH CHIS).

[13] Medicare Hospital Care Compare: Valley Regional Hospital.

[14] NH HealthCost: Valley Regional Hospital (2023). Available at https://nhhealthcost.nh.gov/provider/valley-regional-hospital/quality?carrier=uninsured. Accessed on March 3, 2023.

[15] Valley Regional Healthcare, Community Needs Assessment 2021.

[16] New Hampshire Office of Strategic Initiatives: 2021 Population Estimates for New Hampshire Cities and Towns. Available at https://www.nheconomy.com/getmedia/3d3cae24-c419-4abc-8fd3-7885f517eb1b/population-estimates-2021.pdf . Accessed on March 3, 2023.

[17] New Hampshire Department of Health and Human Services: New Hampshire Medicaid Enrollment. Demographic Trends and Geography, February 2023. Available at https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/bpq-da-medicaid-enrollment.pdf. Accessed on March 3, 2023.

[18] United States Census Bureau: Quick Facts. Available at https://www.census.gov/acs/www/data/data-tables-and-tools/data-profiles/2021/. Accessed on September 30, 2022.

[19] Center for Medicare and Medicaid. (2022, November). November 2022 Medicaid & Chip Enrollment Data highlights. Medicaid. Available at https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html. Accessed on March 5, 2023.

[20] Robert Wood Johnson Foundation County Health Rankings and RoadMaps. Available at https://www.countyhealthrankings.org/explore-health-rankings/new-hampshire/sullivan. Accessed on March 10, 2023.

[21] Centers for Disease Control: Most Recent National Asthma Data – Prevalence. Available at https://www.cdc.gov/asthma/most_recent_national_asthma_data.htm. Accessed on October 2, 2022.

[22] Centers for Disease Control: Most Recent National Asthma Data – Health Care Use. Available at https://www.cdc.gov/asthma/most_recent_national_asthma_data.htm. Accessed on October 5, 2022.

[23] New Hampshire Information and Analysis Center: New Hampshire Drug Monitoring Report, 2020 Overview Report. https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents/2021-11/bdas-dmi-oct-2020.pdf. Accessed October 18 2022.

[24] Centers for Disease Control and Prevention: United States Diabetes Surveillance System – Diagnosed Diabetes. Available at https://gis.cdc.gov/grasp/diabetes/diabetesatlas-surveillance.html. Accessed on October 4, 2022.

[25] Robert Wood Johnson Foundation County Health Rankings and RoadMaps. Available at https://www.countyhealthrankings.org/explore-health-rankings/new-hampshire/sullivan. Accessed on March 10, 2023.

[26] Centers for Disease Control and Prevention: United States Diabetes Surveillance System – Hospitalization (any-listed). Available at https://gis.cdc.gov/grasp/diabetes/diabetesatlas-surveillance.html. Accessed on October 9, 2022.

[27] New Hampshire Information and Analysis Center: New Hampshire Drug Monitoring Report, 2020 Overview Report. https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents/2021-11/bdas-dmi-oct-2020.pdf. Accessed on October 11, 2022.

[28] Centers for Disease Control, National Center for Health Statistics. Drug Overdose Deaths in the US 1999-2021, Data Brief No. 329 (November 2020). Available at https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates#:~:text=Drug%20overdose%20deaths%20involving%20prescription,involving%20prescription%20opioids%20totaled%2016%2C706. Accessed on October 12, 2022.

[29] Substance Abuse and Mental Health Services Administration: Findings from Drug Related Emergency Departments. Available at https://store.samhsa.gov/sites/default/files/pep22-07-03-002.pdf . Accessed on October 13, 2022.

[30] New Hampshire Department of Health and Human Services, Injury Prevention Program. Death Certificate Data provided by the New Hampshire Department of State, Division of Vital Records Administration, 2015-2019. National Rates: CDC Wonder. Available at https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents/2021-11/child-fatality-review-report-2020.pdf Accessed on October 18, 2022.

[31] United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Infant Mortality Rates by State. Available at https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm. Accessed on October 20, 2022.

[32] Centers for Disease Control and Prevention: Persons Living with Diagnosed HIV Infection. Available at https://www.cdc.gov/hiv/library/reports/hiv-surveillance/vol-31/content/living.html. Accessed on October 24, 2022.

ATTACHMENT 2

THE STATE OF NEW HAMPSHIRE

MERRIMACK, SS SUPERIOR COURT

STATE OF NEW HAMPSHIRE,
One Granite Place South
Concord, NH 03301

and

ATTORNEY GENERAL,
DIRECTOR OF CHARITABLE TRUSTS,
One Granite Place South
Concord, NH 03301

Plaintiffs,

v.

VALLEY REGIONAL HEALTH CARE, INC.
243 Elm St.
Claremont, NH 03743,

VALLEY REGIONAL HOSPITAL, INC.
243 Elm St.
Claremont, NH 03743

and

DARTMOUTH-HITCHCOCK HEALTH,
One Medical Center Dr.
Lebanon, NH 03766

Respondents.

Docket No.

_____

[PROPOSED] FINAL JUDGMENT

Plaintiffs State of New Hampshire, by and through its attorneys, the Office of the Attorney General, Consumer Protection and Antitrust Bureau ("State" or "CPAB") and the

Attorney General, Director of Charitable Trusts ("DCT") (collectively, "Plaintiffs" or "Attorney General") filed a Complaint on April 1, 2024 against Valley Regional Healthcare, Inc. ("VRHC"), Valley Regional Hospital, Inc., ("VRH"), and Dartmouth-Hitchcock Health ("D-HH") (collectively, "Respondents"), seeking an injunction and other relief in this matter pursuant to the New Hampshire Combinations and Monopolies Act, N.H. Rev. Stat. Ann. ch. 356; the New Hampshire Consumer Protection Act, N.H. Rev. Stat. Ann. ch. 358-A; and the New Hampshire statutes pertaining to charitable trusts, N.H. Rev. Stat. Ann. ch. 7, secs. 19–32-*l* (and as these statutes are informed by federal antitrust law and policy including the Clayton Act, 15 U.S.C. §§ 18, 26). Plaintiff State, acting through the CPAB, enforces state and federal laws designed to protect free and open markets and fair business practices for the benefit of consumers. *See* N.H. Const., Part II, Art. 83; N.H. Rev. Stat. Ann. chs. 356, 358-A; 15 U.S.C. §§ 18, 26.

Plaintiff State, by and through its Attorney General, also brings this action as *parens patriae* on behalf of and to protect the health and welfare of its citizens and the general economy of the State. *See* N.H. Rev. Stat. Ann. chs. 356, 358-A. The Complaint alleges that the consummation of the proposed transaction under the Integration Agreement and related agreements, whereby D-HH will become the sole corporate member of VRHC, would risk substantially lessening competition in health care markets served by Respondents to the detriment of consumers.

Plaintiff DCT has the common law duty and power to supervise and enforce charitable trusts. *See* N.H. Rev. Stat. Ann. § 7:19–32-*l*; *see also In re Robert T. Keeler Maint. Fund,* 2023 N.H. LEXIS 124, *8–9 (July 13, 2023) (quoting *In re Trust of Mary Baker Eddy*, 172 N.H. 266, 273 (2019) ("the attorney general (or the DCT, as his representative) has the statutory power and

duty to represent the public in the enforcement and supervision of charitable trusts")). The DCT is further required by statute to review any change of control or acquisition transaction of a health care charitable trust to determine compliance with the requirements of N.H. Rev. Stat. Ann. § 7:19-b.

Plaintiff State represents that under the circumstances of this case, the entry of this Final Judgment is in the public interest and will provide a remedy for potential alleged harm to free and fair competition in health care markets in New Hampshire. Plaintiff DCT represents that under the circumstances of this case, the entry of this Final Judgment and compliance therewith will satisfy Respondents' obligations under N.H. Rev. Stat. Ann. § 7:19-b. Respondents contend that the proposed transaction will result in substantial benefits for New Hampshire consumers. Nonetheless, in order to avoid the time, expense, and uncertainty of litigation, the parties agree that this Final Judgment contains the relief agreed to by Plaintiffs and Respondents pursuant to negotiated terms without trial or adjudication of any issue of fact or law, without the Final Judgment constituting any evidence against or admission by any party relating to any issue of fact or law, and without Respondents admitting liability, wrongdoing, or the truth of any allegations in the Complaint.

NOW THEREFORE, IT IS HEREBY ORDERED that the proposed transaction among Valley Regional Healthcare, Inc., Valley Regional Hospital, Inc., and Dartmouth-Hitchcock Health may proceed without undue delay, subject to their compliance with the conditions that follow.

I. JURISDICTION

Pursuant to N.H. Rev. Stat. Ann § 358-A:4, III(a) and agreement with the Respondents, this Court has jurisdiction over the subject matter of the Complaint and this Final Judgment, and over the Respondents named in the Complaint.

II. BACKGROUND

1. VRHC is the parent and sole corporate member of VRH, a critical access hospital ("CAH") located in Claremont, New Hampshire, that serves the surrounding communities in Sullivan County.

2. D-HH is the coordinating organization of a multi-member, integrated academic health system that delivers a full spectrum of health care services to the general public of New Hampshire and Vermont (the "D-HH System"), and is the sole corporate member of Mary Hitchcock Memorial Hospital and Dartmouth-Hitchcock Clinic, which operate jointly as Dartmouth-Hitchcock ("D-H"). The D-HH System is anchored by its flagship hospital Dartmouth Hitchcock Medical Center ("DHMC") located in Lebanon, New Hampshire, and consists of: DHMC; three rural CAHs—New London Hospital located in New London, New Hampshire, Mt. Ascutney Hospital and Health Center located in Windsor, Vermont, and Alice Peck Day Memorial Hospital located in Lebanon, New Hampshire; and two acute care community hospitals—Cheshire Medical Center, located in Keene, New Hampshire and Southwestern Vermont Medical Center located in Bennington, Vermont.

3. Respondents are nonprofit corporations exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code.

4. Respondents executed an Integration Agreement on December 6, 2022, to be amended no later than seven (7) days prior to the Closing Date as provided in Section VI.1.A., to provide for

a change of control of VRHC by D-HH, whereby D-HH becomes the sole corporate member of VRHC (the "Affiliation"), subject to regulatory reviews and other closing conditions.

5. Respondents notified the CPAB and the DCT of the Affiliation and filed a notice of a proposed transaction with the DCT on December 14, 2022 (hereinafter, "DCT Notice"). In accordance with N.H. Rev. Stat. Ann. § 7:19-b, IV (a), the DCT subsequently requested and obtained from the Respondents additional documentation and information regarding the Affiliation. The additional information and documentation submitted by the Respondents are included in the DCT Notice. Pursuant to N.H. Rev. Stat. Ann. § 541-A:29, IV, Respondents entered into written agreements to extend the statutory deadline for the DCT's review under N.H. Rev. Stat. Ann. § 7:19-b, to April 1, 2024.

6. Plaintiff State represents that in the circumstances of this case, the terms and remedies described herein are appropriate and in the public interest and is therefore willing to accept this resolution in lieu of proceeding with an action to permanently enjoin the consummation of the Affiliation.

7. Plaintiff DCT has determined that the Affiliation complies with N.H. Rev. Stat. Ann. § 7:19-b, subject to the terms of the DCT Notice and the terms and conditions set forth herein. The Report of the DCT is attached as an exhibit to this Final Judgment.

8. Plaintiffs reviewed and investigated the proposed transaction pursuant to their separate jurisdictions. In Plaintiffs' view, the most appropriate and efficient manner to resolve Plaintiffs' concerns with the proposed transaction is through the jointly filed Complaint and this Final Judgment.

9. Respondents agree to enter into and comply with this Final Judgment so as to avoid significant expense, inconvenience, and uncertainty, and to permit the Affiliation to close without further delay.

10. This Final Judgment governs the conduct and obligations of Respondents, and any successors or assigns upon closing of the proposed transaction under the Integration Agreement for the Term of the Final Judgment or unless otherwise specified below or as ordered by this Court.

III. CONSTRUCTION

1. This Final Judgment shall be construed pursuant to the laws of the State of New Hampshire and enforced pursuant to the authority of the Merrimack County Superior Court in the State of New Hampshire. The Final Judgment shall be interpreted in accordance with its fair meaning and not against any party hereto.

2. This Final Judgment should be interpreted to give full effect to the procompetitive purposes of consumer protection and antitrust laws and to protect the competition that Plaintiff State alleges may be lessened by the Affiliation. The Final Judgment also should be interpreted to allow Respondents to provide the full benefits of the Affiliation to the communities they serve within the State of New Hampshire. All captions are for convenience only and are not deemed a part of the substantive terms of this Final Judgment.

3. This Final Judgment shall not create a private cause of action or confer any right to any Third Party for violation of any state or federal law by any Respondent except that the Attorney General, acting through the CPAB or the DCT, may file an action or motion to enforce this Final Judgment.

4. Nothing contained in this Final Judgment shall be construed to alter or modify any existing legal rights of any consumer or to deprive any person or entity of any existing private right under the law.

5. Nothing contained in this Final Judgment shall be construed to relieve Respondents of the obligation to comply with all state and federal laws, nor shall it be construed as approval by the Attorney General of any business or governance practices of Respondents.

IV. DEFINITIONS

As used in this Final Judgment:

1. "**Affiliate**" means any Person (other than an individual) that through one or more intermediaries controls, is controlled by, or is under common control with, another Person (other than an individual). As used in this definition, "control" includes the power to direct or cause the direction of the management and policies of a Person (other than an individual).

2. "**Anti-Tiering or Anti-Steering Clause**" means any written or unwritten agreement, term, or practice between a Health Care Provider and a Payor that prohibits the Payor from steering its members to a Hospital or Health Care Provider based on price, access, and/or quality criteria, such as placing the Health Care Provider in a tiered product based on objective criteria determined by the Payor, or that requires the Payor place the Health Care Provider in a particular tier in a tiered health plan product. This includes a gag clause that would prevent a Payor from disclosing cost, access, or quality information to its enrollees, patients or employers.

3. "**Closing Date**" means the effective date when the Affiliation is consummated pursuant to the Integration Agreement.

4. "**Community Needs Assessment**" means the assessment conducted by VRHC, including VRH, as provided in N.H. Rev. Stat. Ann § 7:32-f and 26 U.S.C. § 501(r)(3).

5. "**Dartmouth-Hitchcock Health"** or **"D-HH"** means Respondent Dartmouth-Hitchcock Health, a New Hampshire nonprofit corporation with its headquarters in Lebanon, New Hampshire, its successors and assigns, Affiliates, and their respective directors, officers, managers, agents, and employees.

6. **"D-HH Mid-Level Provider"** means a Mid-Level Provider who has an employment relationship with D-HH, or any D-HH Affiliate.

7. **"D-HH Physician"** means a Physician who has an employment relationship with D-HH, or any D-HH Affiliate.

8. "**Exclusivity Clause**" **or** "**Exclusive Contract**" means any written or unwritten term, agreement, or practice between a Health Care Provider and a Payor that makes D-HH or VRHC an exclusive provider for a particular Payor in a region, prohibits the Payor from contracting with another Health Care Provider, or provides more favorable rates or terms contingent on not contracting with another Health Care Provider.

9. "**Final Judgment**" means this Final Judgment reflecting the agreement between Plaintiffs State of New Hampshire and DCT, and Respondents.

10. **"Health Care Facility"** means any facility located in New Hampshire where Health Care Services are provided, and includes, but is not limited to, ambulatory surgical centers, birthing centers, freestanding emergency rooms, hospitals and specialty hospitals, non-emergency walk-in or urgent care clinics, outpatient clinics, skilled nursing facilities, laboratories, freestanding imaging facilities, and freestanding radiation therapy facilities.

11. **"Health Care Provider"** means a Person who provides Health Care Services and includes but is not limited to Mid-Level Providers, Physicians, other health care professionals,

practices, networks, and other individuals providing Health Care Services, and Health Care Facilities.

12. "**Health Care Services**" means the provision of health or medical care by a Health Care Provider, including but not limited to inpatient and outpatient hospital services, physician and non-physician professional medical services, outpatient medical services, behavioral and mental health services, and ancillary services including but not limited to, laboratory, pharmacy, and imaging.

13. "**Hospital**" means a licensed acute care or other hospital, having a duly organized governing body with overall administrative and professional responsibility and an organized professional staff that provides 24-hour inpatient care, that may also provide outpatient services, and that has as a primary function the provision of inpatient services for medical diagnosis, treatment, rehabilitation, and care of the injured, disabled, or those with short-term or episodic health problems or infirmities.

14. "**Integration Agreement**" means the contractual agreement, and any related amendments, by and among D-HH, VRHC, and VRH titled Integration Agreement, dated December 6, 2022.

15. "**Mid-Level Provider**" means a non-physician provider who performs professional Health Care Services that can be billed independently from that of a Health Care Facility or Physician, including but not limited to advanced practice registered nurses, physician assistants, physical therapists, licensed clinical social workers, psychologists, and other behavioral health counselors, as applicable.

16. "**Most Favored Nations Clause**" means any written or unwritten term, agreement, or practice between a Health Care Provider and a Payor that allows the Payor to receive the benefit

of a better payment rate, term or condition that the Health Care Provider gives to another Payor, that requires a Payor to pay a Health Care Provider a payment rate at least as high as the highest rate paid by the Payor to any other Hospital or Health Care Provider, or that requires a Health Care Provider to accept a payment rate at least as low as the lowest rate paid to the Health Care Provider by any other Payor.

17. **"Payor"** means any organization or entity that contracts with Health Care Providers and other health care organizations to provide or arrange for the provision of Health Care Services to any person or group of persons and that is responsible for payment to such Health Care Providers and other health care organizations of all or part of any expense for such Health Care Services, including but not limited to commercial insurance companies, health maintenance organizations, preferred provider organizations, union trust funds, multiple employer trusts and self-insured health plans.

18. **"Payor-Provider Contract"** means a contract or agreement for Health Care Services between a Health Care Provider and a Payor, including but not limited to rates, definitions, terms, conditions, policies, and pricing methodologies (*e.g.*, per diem, discount rate, and case rate) that relates to the payment of or reimbursement for the Health Care Provider's provision of Health Care Services to the Payor's members or enrollees.

19. "**Person**" means any individual, partnership, association, corporation, business trust, legal representative, any organized group of persons, or government entity, and any subsidiaries, divisions, groups, or affiliates thereof.

20. "**Physician**" means a doctor of allopathic medicine ("M.D.") or a doctor of osteopathic medicine ("D.O.").

21. "**Population Health Arrangement**" means a Payor-Provider Contract involving capitated or other form of risk sharing taken across a population of defined members.

22. "**Pre-Existing Contract**" means a Payor-Provider Contract between a Payor and a Respondent that is in effect on the date that this Final Judgment is entered.

23. "**Term**" has the meaning set forth in Article XIX of this Final Judgment.

24. "**Third Party**" means a Person other than Plaintiff State of New Hampshire, Plaintiff DCT, the CPAB, or the Respondents.

25. "**Tying Clause,**" "**Must Have Clause,**" or "**All-or-Nothing Clause**" means any written or unwritten agreement, term, or practice between a Health Care Provider and a Payor that requires the Payor to contract with one or more, or all, of the contracting Health Care Provider's services, providers, or products in order to contract with any of that Health Care Provider's services, providers, or products.

26. **"Valley Regional Healthcare, Inc."** or **"VRHC"** means Respondent Valley Regional Healthcare, Inc., a New Hampshire nonprofit corporation with its headquarters in Claremont, New Hampshire, its successors and assigns, subsidiaries and Affiliates, including Valley Regional Hospital, Inc. ("VRH") and their respective directors, officers, managers, agents, and employees. VRHC is the parent and sole corporate member of VRH.

27. **"VRHC Mid-Level Provider"** means a Mid-Level Provider who has an employment relationship with VRHC or VRH.

28. **"VRHC Physician"** means a Physician who has an employment relationship with VRHC or VRH.

29. "**VRHC Service Area**" means the cities and towns served by VRHC and VRH identified in VRH's most recent Community Benefits Plan Report.

30. "**Value-Based Payment Arrangement**" means a Payor-Provider Contract under which a Respondent or their subsidiaries are paid or assume risk based on patient health outcomes or some form of quality metrics, instead of being paid on a fee-for-service basis, including, but not limited to, alternative payment models, shared savings programs, pay for performance, bundled payments, capitation, or accountable care organizations.

V. APPLICABILITY

From the date that this Final Judgment is entered and after the Closing Date, the Final Judgment is binding for the Term on Respondents, their directors, officers, managers, employees, and on their successors and assigns, and in the case of VRHC and VRH, all current and future VRHC Affiliates. VRHC shall not permit any VRHC Affiliate or a substantial portion of the assets of VRHC or a VRHC Affiliate to be acquired by any other Person unless that Person agrees in advance and in writing to be bound by the provisions of this Final Judgment and the Respondents provide written Notice to the Attorney General.

VI. COMPLIANCE TERMS

1. **Capital Commitments to Valley Regional Healthcare and Valley Regional Hospital**

A. *Medical Office Building.* No later than seven (7) calendar days prior to the Closing Date, Respondents shall amend Sections 3.6.1 and 3.6.3 of the Integration Agreement to require D-HH to fund the necessary remaining capital required to build a new medical office building ("MOB") for VRHC (the "Remaining MOB Capital"). For avoidance of doubt, the Remaining MOB Capital shall be in addition to and does not include funds VRHC or VRH has previously saved to fund the construction of a medical office building. No later than seven (7) calendar days prior to the Closing Date, Respondents shall provide the Attorney General with a copy of a fully executed Amendment to the Integration Agreement, including the amendment to

Sections 3.6.1 and 3.6.3. Final completion of the MOB shall occur no later than three (3) years after the Closing Date.

B. *EMR Implementation.* D-HH shall fund seventy-five percent (75%) of the capital costs to implement electronic medical records and information technology systems, specifically the Epic and ERP (Peoplesoft) systems, at VRHC and VRH. The EMR implementation shall begin no later than twelve (12) months after final completion of the MOB. The EMR Implementation shall be completed no later than twelve (12) months after the start of the conversion.

C. *Addiction Treatment Center*. D-HH shall fund any necessary expenditures to develop and operate an addiction treatment center at VRHC, which shall offer comprehensive evaluation, treatment, and referral services for individuals with substance use and related disorders (the "Addiction Treatment Center"). Such funding includes but is not limited to, funding related to obtaining space for the treatment center, updating and outfitting the space as necessary to operate the treatment center, and any revenue shortfall related to operating the treatment center.

i. The Addiction Treatment Center shall open within two (2) years of the Closing Date. Respondents shall submit a plan to the Attorney General for review and approval no later than one hundred eighty (180) calendar days after the Closing Date regarding the development of the Addiction Treatment Center such as, at a minimum, necessary funding, proposed staffing, anticipated service offerings, timelines, and related metrics. Such information shall be provided in sufficient detail for the Attorney General to meaningfully review the plan prior to any approval.

ii. Respondents shall operate the Addiction Treatment Center for at least ten (10) years once open to patients. This requirement shall remain in effect and enforceable for ten (10)

years notwithstanding the expiration of the Term of the Final Judgment. Respondents shall collaborate and coordinate care, as necessary, with Hope to Freedom Recovery Home, TLC Family Resource Center, West Central Behavioral Health, and/or any other independent behavioral health provider.

D. *VRH's Vacant Third Floor*. During the Term of the Final Judgment, if Respondents plan to renovate VRH's vacant third floor, Respondents shall submit a plan to the Attorney General no later than sixty (60) calendar days after VRH Board approval of such renovation plan. In developing any plan, the VRH Board may consider VRH's most recent Community Needs Assessment. Any plan developed by Respondents shall include necessary funding, proposed staffing, any anticipated service offerings, timelines, and related metrics. Such information shall be provided in sufficient detail for the Attorney General to meaningfully review the plan prior to its implementation.

E. *Additional Investments*. Nothing in this Section 1 should be construed as limiting additional investments or commitments by Respondents beyond the capital investments and commitments already set forth herein.

2. **Financial Commitment to the State of New Hampshire**

A. D-HH shall pay two million dollars ($2,000,000) directly to the State of New Hampshire, and these funds shall be deposited in the Health Care Consumer Protection Trust Fund established pursuant to N.H. Rev. Stat. Ann. § 7:6-g. ("Funds"). The Funds shall be payable on the Closing Date.

B. The Funds shall be held in the Health Care Consumer Protection Trust Fund and shall be used, administered, and dispersed in accordance with N.H. Rev. Stat. Ann § 7:6-g for the benefit of New Hampshire health care consumers.

3. **Payor-Provider Contracting Restrictions and Terms**

A. *Honor All Pre-Existing Contracts with Payors.* Respondents shall honor all VRHC Pre-Existing Contracts and shall not seek to terminate or renegotiate the terms of such contracts without cause except as required by scheduled expiration, renewal, or by mutual agreement of VRHC and the applicable Payor.

B. *Prohibited Conduct and Contract Terms.* Respondents shall not propose, require, or enter into any Payor-Provider Contract, whether directly by VRHC or VRH, or through any D-HH Affiliate, that includes the following terms or practices, or similar terms or practices that violate the intent or spirit of these prohibitions:

(i) Anti-Tiering or Anti-Steering Clause

(ii) Exclusivity Clause or Exclusive Contract

(iii) Most Favored Nations Clause

(iv) Tying Clause, Must Have Clause or All-or-Nothing Clause

Provided, however, that (1) the prohibited conduct and contract terms are not applicable to the extent that (a) the otherwise prohibited clauses are requested by a particular Payor to be included as a part of a Payor-Provider Contract, and (b) Respondents and the Payor agree that the clause is required for purposes such as a Population Health Arrangement or a Value-Based Payment Arrangement; and (2) this section shall not apply to Respondents' participation in Medicare or Medicaid, or to Medicare Advantage Payor-Provider Contracts (or portions of Payor-Provider Contracts concerning Medicare Advantage).

C. *Prohibitions on Billing Changes.* Respondents shall not bill a D-HH Physician or D-HH Mid-Level Provider as a VRHC Physician or VRHC Mid-Level Provider, or vice-versa,

after the Closing Date if doing so would result in higher billings for the Health Care Services at issue.

4. **Protections for Health Care Providers and Patients**

A. *Compliance with New Hampshire State Law on Physician Contract Restrictions.* Respondents shall comply with state law, N.H. Rev. Stat. Ann. § 329:31-a, and all contracts entered into by Respondents on or after the date the Final Judgment is entered by the Court shall comply with such law. Any existing contract between a Physician and Respondents that includes any restriction of the right of the Physician to practice medicine in any geographic area for any period of time after termination of the contract shall be void and unenforceable with respect to said restriction. Physician contracts, including form contracts, shall be made available to the Attorney General for inspection upon the Attorney General's request to monitor compliance with this term.

B. *Health Care Provider Referral Patterns.* Respondents shall not limit VRHC's employed or contracted Physicians from exercising their professional judgment to refer patients for Health Care Services in the best medical interests of the patient, nor from maintaining their existing patient referral practices. This applies to Physicians whom VRHC may employ or with whom VRHC may contract following the Closing Date.

C. *Notice Regarding Departing Health Care Providers.* If a Physician or Mid-Level Provider who is employed by Respondents leaves their employment or terminates their agreement to provide Health Care Services to Respondents' patients for any reason, Respondents shall provide timely written notice to all patient panels that, at a minimum, (i) informs patients that the Physician or Mid-Level Provider is leaving (or has left), (ii) it is the patient's choice

whether to transfer care, and (iii) upon the patient's or the Physician or Mid-Level Provider's request, informs the patient of the Physician or Mid-Level Provider's new practice location.

D. *Non-Discrimination in Provision of Health Care Services.* Respondents shall not discriminate in the provision of Health Care Services to patients at a Health Care Facility, the release and transfer of medical records or information about such patients based upon the identity or affiliation of a patient's primary care or specialty Physician or Mid-Level Provider, the patient's health plan, or the patient's utilization of Third-Party Health Care Providers.

E. *Non-Discrimination in Patient Transfer and Duty to Communicate.* Respondents shall not refuse to transfer a patient, whether for diagnosis or treatment, to a Health Care Facility other than a D-HH Affiliate Health Care Facility, if such transfer is requested by the patient, the patient's authorized representative, or the patient's Physician or Mid-Level Provider, provided that the patient is stable, the transfer is medically appropriate and legally permissible, and the proposed Health Care Facility accepts the patient. In connection with any such patient transfer, Respondents shall cooperate with the patient, the patient's authorized representative (if applicable), and the Health Care Facility to which the patient is transferred regarding the release and transfer of such patient's medical records.

5. **Facilities, Services, and Programs**

A. *Clinical Services Growth Plan.* No later than one hundred eighty (180) calendar days after the Closing Date, Respondents (with input from Respondents' Integration Committee) shall develop a plan to expand access to certain key Health Care Services in the VRHC Service Area (the "Clinical Services Growth Plan"). The Clinical Services Growth Plan shall include timetables and measurable goals and metrics (including but not limited to ambulatory investments and medical staff recruiting/development) and any requisite funding needs and

sources. The Clinical Services Growth Plan shall be based on relevant clinical needs, including any identified in the most recent VRHC Community Needs Assessment, and including consultation with applicable clinical affiliates, as appropriate. The Clinical Services Growth Plan shall require the approval by the VRH and D-HH Boards, and the VRH Board shall review any modifications during the Term. At a minimum, the Clinical Services Growth Plan shall include plans to expand the following services at VRHC: (1) behavioral health services; (2) alcohol and drug use prevention, treatment, and recovery; (3) prenatal, postnatal, and obstetrical services; (4) cardiology; and (5) oncology. The Clinical Services Growth Plan shall be submitted to the Attorney General, and subject to reporting as further described in Article VII of this Final Judgment. The information submitted in the Clinical Services Growth Plan shall be sufficiently detailed for the Attorney General to conduct a meaningful review.

B. During the Term of the Final Judgment, Respondents shall be required to maintain, and shall maintain the licenses, privileges, necessary staffing, and service offerings required to maintain, the following clinical services by VRHC: (i) women's health services currently offered through once weekly clinics by a Board Certified OBGYN Physician; (ii) prenatal and postnatal care; (iii) mammograms; (iv) operation of the walk-in urgent care seven (7) days per week and the emergency room for twenty-four (24) hours a day and seven (7) days per week; and (v) current level of primary care staffing, including at least two full-time equivalent Physicians and five Mid-Level Providers.

C. D-HH shall provide tele-health or in-person psychiatry services at VRHC for at least ten (10) years from the Closing Date.

D. Respondents shall include effective maternity obstetrical training for treatment into the hospital practice standards for staff and develop an effective discharge process for

patients with a pregnancy diagnosis, including arrangements for follow up care. Respondents shall utilize community resource guides when appropriate.

E. No later than three (3) years after the Closing Date, Respondents shall adopt integrated behavioral health into VRHC primary care practices using D-HH's collaborative care model, subject to the ability to hire additional psychiatrists, APRNs, and licensed clinical social workers.

F. No later than three (3) years after the Closing Date, the D-HH Behavioral Intervention Team model shall be implemented at VRH to evaluate non-behavioral health inpatients for mental health and substance use disorder comorbidities.

G. No later than three (3) years after the Closing Date, VRH shall incorporate effective mental health treatment into the "standards of practice" for hospital staff and shall develop an effective discharge process for patients with suspected or diagnosed mental health or substance use disorders, including arrangements for follow up care. VRH will utilize community resource guides when appropriate.

H. No later than two (2) years after the Closing Date, D-HH shall explore research and teaching opportunities at VRHC, including residencies and grant funded research. D-HH shall provide a report to the Attorney General regarding its research and implementation plan for any teaching opportunities at VRHC in sufficient detail to enable the Attorney General's meaningful review.

I. Respondents shall notify the Attorney General and the Health Care Consumer Protection Advisory Commission at least thirty (30) calendar days before any material reduction in clinical services at VRHC becomes effective. In such notification, Respondents shall demonstrate compliance with Article VI.6.E of this Final Judgment.

6. **Governance of Valley Regional Healthcare and Valley Regional Hospital**

A. As the sole corporate member of VRHC, D-HH shall serve as a fiduciary of VRHC, and its sole member VRH, when exercising its rights pursuant to its reserved powers. *See* N.H. Att'y Gen. Opinion, February 13, 2017.[1]

B. The bylaws of VRHC, VRH, and Mt. Ascutney Hospital and Health Center ("MAHHC") shall be amended and restated as set forth in Section 3.2 of the Integration Agreement and further amended, to the extent they are inconsistent with this Final Judgment. No later than thirty (30) calendar days after adoption, Respondents shall provide the Attorney General with a copy of the amended bylaws for VRHC, VRH, and MAHHC.

C. No later than ninety (90) calendar days after the Closing Date, Respondents shall ensure that those persons who serve concurrently on the Boards of Trustees of VRHC, VRH, and MAHHC shall undergo training with respect to their fiduciary duties to each organization and with respect to identifying and resolving any potential conflicts of interest. Respondents shall ensure that new trustees shall receive such training on this topic no later than ninety (90) calendar days after initiating their board service.

D. D-HH shall ensure that all D-HH Trustees receive annual training with respect to their duties in governing a hospital system comprised of multiple member hospitals. D-HH shall ensure that any persons who will serve concurrently on the boards of D-HH and of a member hospital shall receive additional training and written materials with respect to the heightened awareness of the mission and potential conflicts related to such service.

E. Notwithstanding D-HH's reserved powers, during the Term of this Final Judgment, D-HH shall not effect or approve material reductions in clinical services at VRH in

[1] The February 13, 2017, Opinion Letter issued by the Director of Charitable Trusts is available on the Department of Justice website: https://www.doj.nh.gov/charitable-trusts/documents/corporate-member-fiduciary-duty.pdf.

accordance with section 3.1.2.5 of the Integration Agreement without the affirmative vote of at least two thirds of the VRH trustees then in office, or a greater percentage thereof as may be required by law, VRH's articles of agreement, or VRH's bylaws, at a meeting of the VRH Board at which there is a quorum of trustees.

F. Respondents shall notify the DCT should a dispute arise that requires dispute resolution pursuant to section 5.7.3 of the Integration Agreement.

7. **Charitable Assets of Valley Regional Healthcare and Valley Regional Hospital**

A. Notwithstanding D-HH's reserved powers over VRHC and VRH, reallocation of non-endowment assets of VRH to meet system needs in accordance with section 3.5.5.1 of the Integration Agreement will require the affirmative vote of two thirds of the VRH Trustees then in office. In approving any such reallocation involving pre-transaction assets, the VRH Board must find that a reallocation of its assets will also result in a commensurate benefit to VRH subject to the asset reallocation. During the Term of the Final Judgment, VRH shall provide to the DCT at least sixty (60) calendar days prior written notice of a proposed asset reallocation of VRHC or VRH.

B. Notwithstanding D-HH's reserved powers over VRHC and VRH, donor-restricted assets will not be subject to reallocation and will continue to be used for their donor-restricted purposes.

C. Notwithstanding D-HH's reserved powers over VRHC and VRH, the net proceeds of the sale of any of VRHC and VRH real property and other assets owned by VRHC and VRH on the Closing Date will remain dedicated to VRHC and VRH's charitable purposes in the VRHC Service Area and will not be used for any other purpose.

D. Notwithstanding D-HH's reserved powers, during the Term of the Final Judgment any restricted and unrestricted investment assets of VRHC or VRH that are transferred to the pooled investment accounts managed by D-HH will be identified through unitized sub-accounts and will be subject to the Uniform Prudent Management of Institutional Funds Act, N.H. Rev. Stat. Ann. ch. 292-B.

E. Upon the liquidation or dissolution of VRHC or VRH, or the sale, lease, exchange, or other disposition of all or substantially all of VRHC's or VRH's assets, the proceeds will remain dedicated to VRHC's or VRH's charitable purposes in VRHC's Service Area.

F. Respondents shall implement a fundraising plan for VRHC that does not disadvantage VRHC in support of the D-HH System.

8. **Charity Care Policies**

A. VRHC shall adopt policies for the provision of care to disadvantaged VRHC patients that are no less generous than the written policies of VRHC immediately prior to the Closing Date. In addition, VRHC will not defer, deny, or require a payment before providing medically necessary care because of nonpayment of one or more bills for previously covered care. VRHC patients with unpaid balances who otherwise meet the criteria for financial assistance under VRHC's financial assistance policy in place immediately prior to the Closing Date shall be eligible to receive care under that financial assistance policy.

B. D-HH, VRHC, and MAHHC shall develop a procedure for sharing information such that a patient who qualifies as eligible for uninsured and charity care benefits under one D-HH Affiliate's policy is also approved for financial assistance at any other D-HH Affiliate.

VII. TRANSPARENCY AND REPORTING

In order to facilitate compliance review and the study and research pertaining to Health Care Services and Health Care Providers in New Hampshire, Respondents shall commit to the following terms set forth below.

1. **Annual Report.** Respondents shall provide annual reporting on Respondents' compliance with the Terms of this Final Judgment ("Annual Report"), that includes at a minimum, the following sections, with details to be determined through the development of a Reporting Plan (as further described below). Respondents shall submit to the Attorney General the Annual Report on or before March 31st of each year. Each Annual Report, subject to good faith redactions for Respondents' confidential information, shall be posted on D-HH's and VRH's websites no later than thirty (30) calendar days after the Annual Report is available to the public and provided to the Health Care Consumer Protection Advisory Commission.

A. **Capital Commitments**. Respondents shall report on the following capital commitments at VRHC:

(i) Medical Office Building: Progress in financing and building the MOB;

(ii) EMR Implementation: Progress in financing and installing the new electronic medical system;

(iii) Addiction Treatment Center: Progress in developing, funding, and operating the Addiction Treatment Center; and

(iv) Other Capital Investments for VRHC. Such capital commitments may include the development of the third floor at VRH.

B. **Clinical Services Growth Plan**. Respondents shall report on performance results and compliance relating to the Clinical Services Growth Plan, including progress with respect to timetables, measurable goals and metrics, and requisite funding as applicable.

C. **Cost Savings**. Respondents shall report on analyses of financial data detailing cost savings as a result of reduction of redundant operations, improved efficiencies related to patient care, and shifting sites of care.

D. **Community-Based Care**. Respondents shall report on performance results with respect to maintaining and expanding care in the VRHC Service Area.

E. **Payors/Contracting**. Respondents shall report on compliance with contracting terms and practices described above in Article VI.3 of this Final Judgment. The Attorney General may inspect Payor-Provider Contracts to confirm compliance. D-HH shall report on all D-HH Affiliates' participation in Value-Based Payment Agreements and steering/tiering initiatives.

F. **Service Offerings**. Respondents shall report on current service offerings, cessation of material services, and closure of facilities, including compliance with Article VI.6.E of this Final Judgment.

G. **Charity Care**: VRHC shall report on its spending and programming for charity care (as defined in N.H. Rev. Stat. Ann. § 7:32-d, I) and for meeting relevant community needs as identified in VRHC's Community Needs Assessment (described in N.H. Rev. Stat. Ann. § 7:32-f).

2. **Attorney General Consultant and Authority.**

A. No later than sixty (60) calendar days after the Closing Date, the Attorney General shall select and retain a consultant (hereinafter "Consultant"). The Consultant shall

assist the Attorney General in developing a framework for the Annual Report, with timely input from the Respondents, to ensure meaningful transparency and compliance with the Final Judgment after the Closing Date. D-HH shall be solely responsible for payment of all fees and expenses of the Consultant.

B. The Consultant's authority and scope of work shall be limited to the development of the reporting framework, including the necessary elements and criteria for the Annual Report and process for submission of information and materials Respondents in good faith believe constitutes confidential information, including the specific statutory or other legal basis for the assertion of confidentiality ("Reporting Plan"). The Reporting Plan shall be subject to the review and approval by the Attorney General. The Consultant's authority and scope of work shall not include the determination of the type of Health Care Services or the manner in which those Health Care Services are to be provided by the Respondents.

C. Respondents shall cooperate with the Attorney General and the Consultant in providing timely input regarding the Reporting Plan.

D. Respondents shall certify that each Annual Report required by this Final Judgment is in compliance with the Reporting Plan.

E. The Attorney General shall maintain audit and inspection rights related to the Annual Reports including, but not limited to, inspecting records, requiring Respondents to produce documents and information used to develop the Annual Reports, requesting information from Payors, and meeting with the Respondents together or separately, as requested or determined by the Attorney General.

F. Respondents waive any confidentiality obligations owed to them on the part of any Third Party who has records or other information of Respondents that is relevant to the

Respondents' compliance with this Final Judgment, provided that such waiver shall not waive confidentiality with respect to disclosure by the Attorney General or the DCT to any other person.

3. **Data Submission to New Hampshire All Payor Claims Database**

A. Respondents shall submit, or shall cause their third-party administrator to submit, in a timely, complete, and accurate manner all Payor claims and related data and information with respect to their self-funded employer sponsored plans to the New Hampshire Comprehensive Health Care Information System ("NH CHIS") consistent with N.H. Rev. Stat. Ann. § 420-G:11, related regulations including N.H. Code Admin R. Ins. 4005.03, guidance, and reporting forms (including any amendments or updates thereto). As part of this submission, Respondents shall provide any historical data not previously submitted since 2016. Submissions shall include: (i) all data specific therein for Respondents and any Affiliates, with all employees and membership of the self-insured health benefit plan(s); and (ii) Group Identification information.

B. No later than three (3) months after the Closing Date, Respondents shall execute any and all opt-in forms (*e.g.*, All-Payer Claims Database Indication of Intent for Private Employers Offering Self-funded Health Coverage in New Hampshire) and all necessary agreements with any Third Party to submit any historical claims and ongoing claims data to NH CHIS.

C. Timely, accurate, and complete reporting and submission for this Section shall include but is not limited to: (i) submission, standardized formatting, and compliance standards of NH CHIS under state law; and (ii) diligently interfacing with any Third Party for any agreements and other communication necessary for compliance.

4. **Annual Submissions of Health Care Provider and Facility Information.** No later than March 31, Respondents shall annually submit to the Attorney General and the Health Care Consumer Protection Advisory Commission as a public record:

A. A list of Health Care Providers on VRH's medical staff, as reasonably available, including those employed by VRHC and Affiliates providing the following information: (a) first and last name; (b) practitioner NPI that is valid and non-duplicative (*i.e.*, unique value); (c) primary service location address for patients (including facility type such as hospital, urgent care, professional practice, ambulatory surgical center, or other); (d) any billing NPIs used to submit claims for each identified individual Health Care Provider at any time during the year; (e) specialty assignment designation based on the Health Care Provider's predominant area of actual practice; and (f) designation of whether each Health Care Provider is employed or affiliated, whichever is applicable during the submission set;

B. A list of licensed Health Care Facilities located in New Hampshire that VRHC, VRH, or D-HH owns or controls, or on whose behalf the entity submits billing claims to Payors. Such list shall include, for each Health Care Facility: (a) the corporate and d/b/a name; (b) physical location/address; (c) New Hampshire facility license number; (d) facility NPI that is valid and non-duplicative (i.e. unique value); and (e) the primary Health Care Services currently offered; and

C. A description of material expansions, relocations, or closures of locations or sites of Health Care Services, owned or controlled by Respondents or their Affiliates in New Hampshire, including the date of closure or relocation.

VIII. CONFIDENTIALITY

1. Respondents understand that materials submitted to the Attorney General after the Closing Date shall be available to the public in accordance with state law, including the New Hampshire Right-to-Know Law, N.H. Rev. Stat. Ann. ch. 91-A. Respondents may request confidential, nonpublic treatment of any portion of their submission materials that they consider in good faith to be confidential, containing trade secrets, or commercially sensitive information not subject to public release consistent with applicable law.

2. To the full extent permitted by law, the Attorney General will treat and maintain all confidential submission materials clearly designated and marked by Respondents as confidential in accordance with and within pertinent exemptions from public disclosure provided in N.H. Rev. Stat. Ann. ch. 91-A. In the event the Attorney General receives a public records request that calls for the disclosure of Respondents' submission materials designated and marked confidential, the Attorney General will notify Respondents as soon as reasonably practicable upon receipt of any such request and the Attorney General's legal position with respect to such request. The Attorney General further agrees to not produce any such records until at least fifteen (15) calendar days after having given notice of the request to Respondents, to enable them reasonable time to seek judicial review or otherwise make arrangements to secure confidential treatment of the submission materials.

IX. NOTICE OBLIGATIONS

1. **Notice of Consummation**

Respondents shall not effectuate or consummate the Affiliation until this Final Judgment is entered by the Court. No later than five (5) business days following the Closing Date,

Respondents shall provide written notice of the Closing Date, together with a copy of the executed transaction documents to the Attorney General.

2. **Notice of Final Judgment**

A. No later than seven (7) calendar days after the Closing Date, and throughout the Term of this Final Judgment, Respondents shall publicly post on the websites of VRH and D-HH a copy of this Final Judgment after it is entered by the Court and throughout the Term of this Final Judgment.

B. No later than thirty (30) calendar days after the Closing Date, Respondents shall:

(i) Provide a copy of this Final Judgment to the Board of Trustees and statutory officers for each Respondent, and shall provide the Final Judgment to newly appointed Board members, appointed during the Term, upon commencement of each Board member's term of office; and

(ii) Provide a summary of the terms of the Final Judgment to Respondents' executive management employees and Physicians.

C. No later than thirty (30) calendar days after the Closing Date, VRH shall provide a copy of this Final Judgment to any Payor that has a Pre-Existing Contract.

X. COMPLIANCE INSPECTION

If the Attorney General has a reasonable belief that the Respondents are not in compliance with this Final Judgment or related orders, and upon written request of the Attorney General, with reasonable notice (at least fourteen (14) calendar days) to Respondents, Respondents must permit (subject to legally recognized privileges) the Attorney General, including any retained agents or consultants:

1. To have reasonable access during Respondents' and/or their Affiliates' regular business hours to inspect and copy, or at the option of the Attorney General, to require Respondents and/or their Affiliates to provide electronic copies of books, ledgers, accounts, records, data, and documents in the possession, custody, or control of Respondents and/or their Affiliates relating to compliance with the terms of this Final Judgment; and

2. To interview Respondents' or their Affiliates' officers, employees, or agents relating to compliance with this Final Judgment.

XI. NO RETALIATION

Respondents shall amend within one hundred eighty (180) calendar days of the Closing Date their whistleblower policies to include good faith reports made to the Attorney General by any director, officer, or employee of alleged noncompliance with any term of this Final Judgment, including annual reporting, and to bar retaliation against any person with respect to such reports. Retaliation includes, but is not limited to, conduct that impedes or prevents any Person from providing information to the Attorney General or their agents related to the terms of this Final Judgment.

XII. ENFORCEMENT, VIOLATION, AND CURE

1. The Attorney General shall have exclusive jurisdiction to seek court enforcement of this Final Judgment against Respondents. If the Attorney General believes there has been a violation of this Final Judgment, the Attorney General shall provide Respondents advanced notice thereof and grant a reasonable opportunity to cure any such alleged violation. If such alleged violation is not cured by Respondents within sixty (60) calendar days of the date Respondents receive the notice, the Attorney General may thereafter seek to undertake appropriate remedial action. The sixty-day period shall be extended upon Respondents' written request at the Attorney General's

discretion in circumstances where Respondents provide an explanation as to why sixty days is inadequate to cure the alleged violation. These time periods may be adjusted in the event of exigent circumstances, as determined by the Attorney General.

2. Any Person who believes they have been aggrieved by a violation of this Final Judgment may file a complaint with the Attorney General for review. If, after the Attorney General's review, the Attorney General believes either a violation of the Final Judgment has occurred or additional information is needed to evaluate the complaint, the Attorney General may, in his or her discretion, forward a copy of the complaint to the Respondents for a response. If, after receiving and reviewing the response, the Attorney General believes a violation of the Final Judgment has occurred, it shall advise the Respondents, and give time to cure and take necessary action as provided in Section XII.1.

3. The Attorney General retains and reserves all rights to seek an order of contempt and appropriate legal and equitable relief from the Court. Respondents agree that in a civil contempt action, a motion to show cause, or a similar action brought by the Attorney General regarding an alleged violation of this Final Judgment, the Attorney General may establish a violation of this Final Judgment and the appropriateness of a remedy therefor by a preponderance of the evidence. If the Court determines that the Respondents violated this Final Judgment, the Court may require payment of the Attorney General's costs of investigation and enforcement, including legal fees, expenses and court costs.

4. No Person shall have the right to enforce the Final Judgment other than the Attorney General or the Respondents.

XIII. FEES AND COSTS

1. Within sixty (60) calendar days after the Closing Date, Respondents shall directly pay the Attorney General's retained consultants for the reasonable fees and costs incurred by the CPAB related to its investigation of this matter, but not to exceed $325,000.00 for consultant fees and costs, pursuant to N.H. Rev. Stat. Ann. § 356:10, VI, and pay the Attorney General $196,700.00 for CPAB's fees and costs, pursuant to N.H. Rev. Stat. Ann. §§ 356:4-b, 358-A:6, IV.

2. Respondents shall pay for reasonable fees and costs that are incurred by the Attorney General related to the investigation and/or resolution of any dispute arising between the Attorney General and the Respondents throughout the Term of this Final Judgment.

XIV. NOTICE

1. Any notice, demand, or communication required, permitted, or desired to be given hereunder, shall be in writing and deemed effectively given when mailed by prepaid certified or registered mail, return receipt requested, addressed as follows, with courtesy copies sent contemporaneously by email ("Notice"):

***If to the Attorney General*:**

Department of Justice
Office of the Attorney General
c/o Charitable Trusts Unit and Consumer Protection and Antitrust Bureau
One Granite Place South
Concord, New Hampshire 03301

With copy by email to:

Michael Haley, Director of Charitable Trusts
Michael.R.Haley@doj.nh.gov

Alexandra C. Sosnowski, Assistant Attorney General
Consumer Protection and Antitrust Bureau
Alexandra.C.Sosnowski@doj.nh.gov

If to Respondent D-HH:

Dartmouth-Hitchcock Health
One Medical Center Drive
Lebanon, NH 03766

With copy by email to:

John Kacavas, Chief Legal Officer and General Counsel
John.P.Kacavas@hitchcock.org

If to Respondent VRHC or VRH:

Valley Regional Healthcare, Inc.
Valley Regional Hospital, Inc.
243 Elm St.
Claremont, NH 03743
ATTN: President

2. Upon request of the sending party, the party receiving a Notice pursuant to this Section XIV may waive the requirement that Notice by given by physical mail; such waiver shall not be construed as applying to any future Notice.

3. Respondents shall provide the Attorney General with ten (10) calendar days' advance notice of any changes to designated Notice contacts under this Article.

XV. AVERMENT OF TRUTH AND FURTHER ASSURANCES

1. Respondents have averred that, to the best of their knowledge, the information they have provided to the Attorney General, the CPAB, and the DCT in connection with the Attorney General's review and investigation of the Affiliation is true in all material respects.

2. Respondents shall cooperate and take such actions as may be reasonably requested by the Attorney General, the CPAB, and the DCT in order to carry out the provisions and purposes of this Final Judgment.

XVI. ENTIRE AGREEMENT OF THE PARTIES

The terms of this Final Judgment contain the entire agreement of Respondents hereto, and there are no agreements or representations which are not set forth herein. No other promises, representations, inducements, or agreements of any nature have been made or entered into by Respondents. Respondents acknowledge that this Final Judgment constitutes a single and entire agreement that is not severable or divisible, except that if any provision herein is found to be legally insufficient or unenforceable then the remaining provisions shall be construed in order to effectuate the purposes hereof and the validity, legality, and enforceability of the remaining provisions contained herein shall not in any way be affected or impaired thereby.

XVII. MODIFICATION

If the Attorney General or Respondents believe that modification of this Final Judgment would be in the public interest, the requesting party shall give Notice to the other party and the parties shall attempt to agree on a modification. If the parties agree on a modification, they shall jointly modify the Final Judgment and present the modification for approval and entry by the Court. If the parties cannot agree on a modification, the requesting party may petition the Court to modify this Final Judgment.

XVIII. RETENTION OF JURISDICTION

This Final Judgment shall remain in full force and effect until further order of the Court, subject to Article XIX of this Final Judgment. During the Term of this Final Judgment, this Court shall retain jurisdiction to enable any party to the Final Judgment to apply to this Court for such further orders and directions as may be necessary and appropriate for the interpretation, modification, and enforcement of this Final Judgment.

XIX. TERM OF THE FINAL JUDGMENT

This Final Judgment shall expire ten (10) years from (a) the date it is entered by the Court or (b) the Closing Date, whichever is later (the "Term"). Any provision of this agreement not otherwise required by applicable law shall only be applicable for the Term. The Term may be otherwise modified by mutual agreement of Respondents and the Attorney General, with approval of the Court.

XX. PUBLIC INTEREST DETERMINATION

Entry of this Final Judgment is in the public interest based on the record before the Court.

AGREED TO AND ENTRY OF THIS FINAL JUDGMENT IS REQUESTED BY:

On behalf of the State of New Hampshire

By its attorney,

JOHM M. FORMELLA
ATTORNEY GENERAL

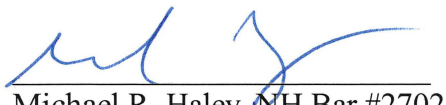
Brandon H. Garod, NH Bar #21164
Senior Assistant Attorney General
Consumer Protection and Antitrust Bureau
New Hampshire Department of Justice
Office of the Attorney General
One Granite Place South
Concord, NH 03301-6397
Brandon.H.Garod@doj.nh.gov

Date: April 1, 2024

Alexandra C. Sosnowski, NH Bar #268996
Assistant Attorney General
Consumer Protection and Antitrust Bureau
New Hampshire Department of Justice
Office of the Attorney General
One Granite Place South
Concord, NH 03301-6397
Alexandra.C.Sosnowski@doj.nh.gov

Date: April 1, 2024

On behalf of the Attorney General,
Director of Charitable Trusts



Michael R. Haley, NH Bar #270236
Director of Charitable Trusts
New Hampshire Department of Justice
Office of the Attorney General
One Granite Place South
Concord, NH 03301-6397
Michael.R.Haley@doj.nh.gov

Date: 4/1/2024

On behalf of Respondent Valley Regional Healthcare, Inc.

By: _____
Patricia Putnam
Board Chair
Valley Regional Healthcare, Inc.
243 Elm St.
Claremont, NH 03743

On behalf of Respondent Valley Regional Hospital, Inc,

By: _____
Patricia Putnam
Board Chair
Valley Regional Hospital, Inc.
243 Elm St.
Claremont, NH 03743

On behalf of Respondent Dartmouth-Hitchcock Health

By: _____
John P. Kacavas, Esq.
Chief Legal Officer and General Counsel
Dartmouth-Hitchcock Health
One Medical Center Dr.
Lebanon, NH 03766