February 24, 2020

Thomas J. Donovan, Esq.
Director of Charitable Trusts
New Hampshire Department of Justice
33 Capitol Street
Concord, H 03301-6397

Re: GraniteOne Health/Dartmouth-Hitchcock Health Acquisition Transaction

Dear Director Donovan:

The following is in response to your February 3, 2020 request for additional information in connection with the Joint Notice filed under RSA 7:19-b by GraniteOne Health (GOH), Catholic Medical Center (CMC), Monadnock Community Hospital (MCH), Huggins Hospital (HH) and their affiliates regarding their proposed transaction with Dartmouth-Hitchcock Health (D-HH). The responses follow each specific request of your February 3rd letter, and in some cases refer to documents appended to this response. The parties reserve the right to supplement these responses if additional information becomes available after their submission.

FINANCIAL MATTERS

1. **Please state the rates received from commercial payers and Medicare in 2019 for at least ten tertiary and/or quaternary services at named "high-cost Massachusetts providers" and compare them with the rates received for those same services at CMC and D-HH. Notice Document, p. 3, 6. Chartis report.**

   Commercial rates for Massachusetts hospitals by service are not publicly available. Thus, the parties have relied on aggregate data to compare the relative rates of high-cost Massachusetts providers to CMC. The primary source of this information is research undertaken by researchers at the RAND Corporation and published in 2019 as part of a report titled, "Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely." This study reports the average allowed amount per inpatient stay, standardized to an MS-DRG relative weight equal to one ("standardized price"), based on CY2015-2017 data. Below are the reported standardized prices for CMC, DHMC, and prominent high-cost Massachusetts providers:

   - CMC: $16,587
   - DHMC: $20,976
   - Brigham and Women's Hospital: $31,815
   - Beth Israel Deaconess Medical Center: $24,332
   - Massachusetts General Hospital: $31,147
   - Lahey Hospital and Medical Center: $19,793

   Medicare payments for CMC, DHMC, and select high-cost Massachusetts providers are available through the Centers for Medicare & Medicaid Services' PC Pricer tool (FY19),

which calculates payments to hospitals for inpatient services based on the Prospective Payment System. Below is a comparison of Medicare payments for a sample of tertiary/quaternary inpatient services across CMC, DHMC, and prominent high-cost Massachusetts providers:

			Total Payment ($)					
Service Line	**MS-DRG**	**Description**	*CMC*	*DHMC*	*BWH*	*BIDMC*	*MGH*	*Lahey*
Bariatrics	621	O.R. PROCEDURES FOR OBESITY W/O CC/MCC	10,955	15,759	17,436	17,732	17,038	15,282
Spine/Pain	029	SPINAL PROCEDURES W CC OR SPINAL NEUROSTIMULATORS	21,434	30,089	33,030	33,813	32,581	29,667
Spine/Pain	455	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W/O CC/MCC	33,686	47,147	51,262	52,615	50,753	46,485
Orthopedics	467	REVISION OF HIP OR KNEE REPLACEMENT W CC	23,525	32,966	36,141	37,021	35,682	32,537
Orthopedics	469	MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W MCC OR TOTAL ANKLE REPLACEMENT	21,557	30,257	33,213	34,001	32,763	29,836
Heart/Vascular	220	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W CC	35,050	49,051	53,292	54,708	52,776	48,357
Heart/Vascular	235	CORONARY BYPASS W/O CARDIAC CATH W MCC	39,067	54,656	59,269	60,871	58,733	53,871
Trauma (Orthopedics)	481	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC	14,170	20,156	22,221	22,666	21,807	19,696
Trauma (Orthopedics)	482	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W/O CC/MCC	11,528	16,542	18,288	18,611	17,888	16,068
Cancer	375	DIGESTIVE MALIGNANCY W CC	8,486	12,383	13,763	13,943	13,377	11,894

Note: assumes a 5 day length of stay

2. State the amount of additional fees, if any, likely to be paid from a) commercial payers and b) Medicare for Dartmouth-Hitchcock Clinic (D-HC) services in Region II, because of the ability to charge facility fees and medical education payments due to the proximity of D-HC facilities to CMC as part of D-HHGO. Chartis Report.

We do not anticipate any additional fees to be paid by either commercial payers or Medicare related to D-HC services in Region II due to the proximity of D-HC facilities to CMC. D-HC does not receive Medicare payments for medical education for its services. Regarding facility fees, D-HC does not intend, nor would D-HC be allowed under Medicare rules, to charge facility fees due to its proximity to CMC. In fact, D-HC is building an extended stay ambulatory surgery center on its Manchester Wellington Road campus that will be reimbursed at free-standing ASC rates. The expectation is that this facility will be able to treat a number of patients who currently receive their lower acuity surgical care at hospitals. The surgery center will be a lower cost site than hospitals for patients and payers.

3. How does the contemplated efficiency opportunities of $12.5 million to $32 million (over 3 years) compare with realized savings achieved through other hospital system integrations of comparable size? PYA, Executive Summary Report of Efficiency Opportunities.

The contemplated efficiency opportunities quantified by PYA of $12.5 million to $32 million is a net savings of approximately 1 to 2% of the total aggregate annual expenses of the GraniteOne Health members using gross expenses of $651 million for the year-ending September 30, 2019. This is in line with the range of realized savings achieved through other hospital system integrations of comparable size. PYA described their experience and benchmarking in the Executive Summary Report of Efficiency Opportunities (the "PYA Report"). Beginning on page 11 and expanding through page 14 of the PYA Report, PYA notes that the typical range of efficiencies that they have seen average, over time, 0 – 3% for

labor efficiencies and 1 to 4% for non-labor efficiencies. *See Appendix IV(3).* It is important to note that the estimate of 1 to 2% for D-HH GO is based on analyses of actual data from the two systems to estimate a range of expected savings in certain identified efficiency areas. Specific data utilized, analyses performed, and key observations from application of that analysis are documented in the summaries for each efficiency area in the PYA Report. Furthermore, there are noted additional possible opportunities which may materialize if further analysis and detailed integration planning is performed, as the Report is limited in scope. The parties expect additional savings to develop in the future and through the parties' continued integration planning efforts.

The scope of the PYA engagement was limited by management to the areas of supply chain and group purchasing, human resources and staffing synergies, insurance, laboratory and ancillaries, rural hospitals, cost of capital reductions and purchased services. These areas were identified by management because they were viewed as realistic opportunities that could be achievable within the first three years, which are only achievable because of the level of integration contemplated by the Proposed Combination and which would require limited investment to achieve the benefits. Second, the savings noted are primarily driven by supply chain integration and group purchasing opportunities. Continued work is expected through the integration planning to identify and advance additional savings and efficiency opportunities.

(*intentional page break*)

4. Identify the value or risk-based contracts in which D-HH has participated since 2015, as well as the number of patients managed through each such contract each year, broken out by categories (commercial payers, Medicare and Medicare) and the plans for new or different risk-based contracts following the pending transaction. Chartis Report, pp 56 - 57.

DARTMOUTH-HITCHCOCK HEALTH
Attributed Lives by Value-Based/Risk Contract
For the Years 2015 - 2020

Name of Value-Based/Risk Contract	2015	2016	2017	2018	2019	2020	
Commercial							
Anthem/D-H Commercial ACO Shared Risk	45,236	44,270	44,362	37,763	38,794	40,650	
Anthem/D-H Commercial ACA Exchange MLR Shared Savings	Not Applicable	Not Applicable	Not Applicable	2,828	1,768	2,755	
Anthem/MHMH Commercial Virtual Panel Shared Savings	Not Applicable	Not Applicable	Not Applicable	2,409	2,392	2,082	
Anthem/APD Commercial Virtual Panel Shared Savings	Not Applicable	Not Applicable	Not Applicable	1,432	1,432	1,257	
Anthem/NLH Commercial Virtual Panel Shared Savings	Not Applicable	Not Applicable	Not Applicable	2,329	2,329	2,569	
Anthem/D-H Medicare Advantage Shared Savings	Not Applicable	Not Applicable	Not Applicable	Not Applicable	628	613	
Benevera/HPHC/D-H/Cheshire/NLH Primary Risk Shared Risk	Not Applicable	19,072	18,931	15,583	15,512	13,859	
Benevera/HPHC/D-H Medicare Advantage Shared Savings	Not Applicable	Not Applicable	894	894	1,652	1,840	
Cigna/D-H CAC Shared Savings	21,745	20,717	18,516	15,783	17,717	21,382	
ElevateHealth/D-H Shared Risk	465	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	
HPHC/D-H Shared Risk	12,653	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	
OneCare Vermont ACO/D-H - BCBSVT Commercial QHP Shared Risk	Not Applicable	Not Applicable	Not Applicable	1,054	1,131	1,007	
OneCare Vermont ACO/MAHHC - BCBSVT Commercial QHP Shared Risk	Not Applicable	Not Applicable	Not Applicable	Not Applicable	1,227	1,255	
OneCare Vermont ACO/D-H - BCBSVT Commercial QHP Shared Savings	1,591	1,613	1,098	Not Applicable	Not Applicable	Not Applicable	
OneCare Vermont ACO/MAHHC - BCBSVT Commercial QHP Shared Savings	963	1,188	1,148	Not Applicable	Not Applicable	Not Applicable	
OneCare Vermont ACO/D-H - BCBSVT Commercial Primary Shared Savings	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	To be determined	New in 2020
OneCare Vermont ACO/D-H - MVP Commercial Primary Shared Savings	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	To be determined	New in 2020
OneCare Vermont ACO/D-H - UVMMC Self-Funded Employee Health Benefit Plan Shared Savings	Not Applicable	Not Applicable	Not Applicable	8	8	8	
OneCare Vermont ACO/MAHHC - UVMMC Self-Funded Employee Health Benefit Plan Shared Savings	Not Applicable	Not Applicable	Not Applicable	18	18	18	
Medicare							
CMS/D-HH Accountable Care LLC Next Generation ACO Shared Risk	Not Applicable	Not Applicable	19,778	19,588	Not Applicable	Not Applicable	
OneCare Vermont ACO/MAHHC - Modified Next Generation ACO Shared Risk	Not Applicable	Not Applicable	Not Applicable	Not Applicable	3,036	3,024	
OneCare Vermont ACO/MAHHC Medicare Shared Savings	2,009	1,962	1,792	Not Applicable	Not Applicable	Not Applicable	
Medicaid							
NH Healthy Families/D-H - NH Medicaid Shared Savings	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	7,697	New in 2020
OneCare Vermont ACO/D-H - VT Medicaid Shared Risk	Not Applicable	Not Applicable	Not Applicable	947	1,289	2,308	
OneCare Vermont ACO/MAHHC - VT Medicaid Shared Risk	Not Applicable	Not Applicable	Not Applicable	920	1,650	1,814	
OneCare Vermont ACO/D-H - VT Medicaid Shared Savings	999	1,000	Not Applicable	Not Applicable	Not Applicable	Not Applicable	
OneCare Vermont ACO/MAHHC - VT Medicaid Shared Savings	912	915	Not Applicable	Not Applicable	Not Applicable	Not Applicable	
Total Attributed Lives across all D-HH Value-Based/Risk Contracts	84,662	88,822	106,519	100,636	88,933	102,324	

D-HH plans to continue these risk contracts following the pending transaction. Expanding these contracts or entering new contracts will be subject to discussion with payers.

5. State the percentage of patient service revenues at CMC, MCH, HH, and D-HH that were derived from value or risk-based arrangements (accountable care organizations, etc.) in each year from 2015 through 2019, broken out if possible by categories: commercial payers, Medicare and Medicaid. GO 2018 Combined Financial Statements, Note 3.

CMC: *See Attachment 1* (Table of Patient Service Revenue Derived from Value or Risk-based Arrangements (Confidential/Exempt from Public Disclosure Pursuant to RSA 91-A:5, IV (financial information)).

MCH:

Fiscal Year	Medicare	Medicaid	Commercial Payors	Total
FY'15	0.01%	0.14%	0.88%	**1.03%**
FY'16	0.02%	0.06%	0.55%	**0.63%**
FY'17	0.00%	0.27%	0.33%	**0.61%**
FY'18	0.00%	0.17%	0.46%	**0.62%**
FY'19	0.00%	0.12%	0.51%	**0.63%**

HH: *See Attachment 2* (Confidential/Exempt from Public Disclosure Pursuant to RSA 91-A:5, IV (financial information)).

D-HH Response:
Under its risk-based contracts, D-HH is responsible for the total cost of care for its attributed patients regardless of whether those costs are incurred within the D-HH system or at non-D-HH facilities. Therefore, calculating the percent of D-HH patient service revenue that is derived from risk contracts understates the total cost of care that D-HH is responsible for managing. In addition, the level of claims information provided to D-HH by insurers varies and often lacks complete information to accurately determine if those claims were incurred within the D-HH System or external to the D-HH System. In response to the question, however, we calculated the following percentages:

Percentage of Patient Service Revenues for D-H Derived From Risk Based Contracts (Based on Fiscal Years July-Jun)

2015	2016	2017	2018	2019*
13%	11%	15%	15%	12%

*The lower percentage in 2019 is due to D-H not participating in the CMMI Next Generation Medicare ACO Model after 2018

6. Submit the data supporting the statement that D-HH's commercially insured patients have the second lowest per member per month costs in New Hampshire.

This statement is based on a presentation ("Value-Based Public & Private Payment Landscape in New Hampshire") that was delivered by researchers at the University of New Hampshire on June 26, 2019. The lead presenters were Jo Porter, MPH, Director, Institute for Health Policy and Practice and Lucy Hodder, Professor of Law, Director of Health Law and Policy, Franklin Pierce School of Law, Institute for Health Policy and Practice.

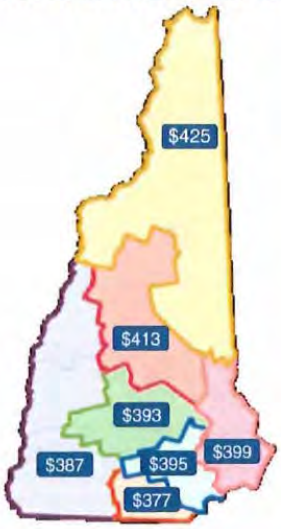
According to this presentation, from July 2017 to June 2018, the integrated delivery network (IDN) managed by D-HH (IDN 1 Greater Monadnock, Greater Sullivan County, and Upper Valley Region) saw commercial per member per month (PMPM) costs of $387; the only other IDN with lower costs was IDN 3 ($377).

This presentation also showed that from January 2017 to December 2017, D-HH's IDN had the lowest PMPM Medicaid costs of any IDN in the state.

For reference, the relevant figures from the presentation are provided below.

Institute for Health Policy and Practice

Commercial Medical Costs, Regional PMPM



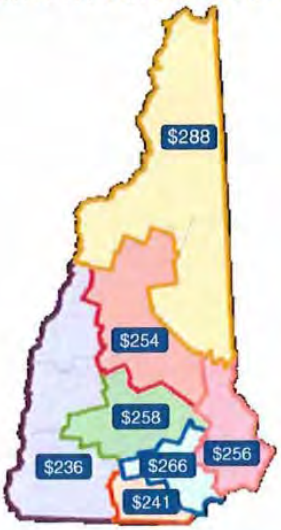
IDN	PMPM, 7/2017-6/2018
IDN 1 Greater Monadnock, Greater Sullivan County, Upper Valley Region	$387
IDN 2 Capital Area Region	$393
IDN 3 Greater Nashua Region	$377
IDN 4 Greater Derry, Greater Manchester Region	$395
IDN 5 Central NH, Winnipesaukee Region	$413
IDN 6 Strafford County, Seacoast Region	$399
IDN 7 North Country, Carroll County Region	$425

Source: Data analysis of NH Comprehensive Healthcare Information System (NHCHIS) completed by Center for Health Analytics, IHPP; Commercial claims data year is July 2017-June 2018

Map recreated from https://www.dhhs.nh.gov/section-1115-waiver/documents/nh-dsrip-towns-by-idn-region.pdf

Institute for Health Policy and Practice

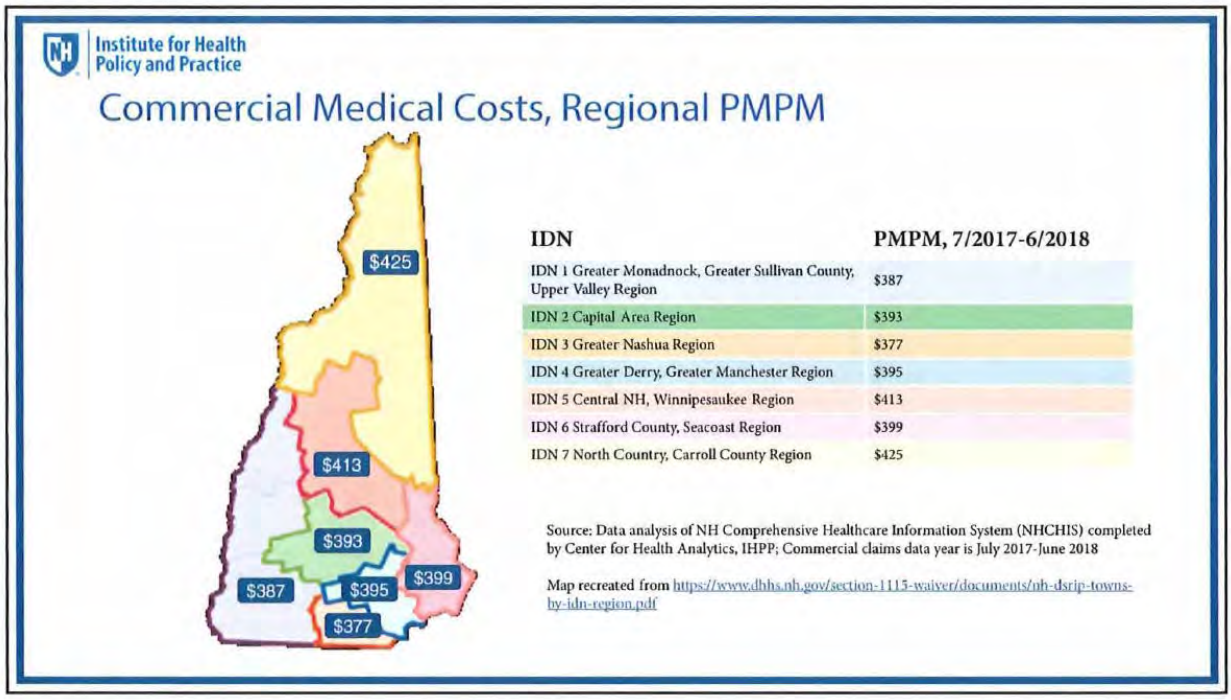
Medicaid Medical Costs, Regional PMPM



IDN Key	PMPM, 1/2017-12/2017
IDN 1 Greater Monadnock, Greater Sullivan County, Upper Valley Region	$236
IDN 2 Capital Area Region	$258
IDN 3 Greater Nashua Region	$241
IDN 4 Greater Derry, Greater Manchester Region	$266
IDN 5 Central NH, Winnipesaukee Region	$254
IDN 6 Strafford County, Seacoast Region	$256
IDN 7 North Country, Carroll County Region	$288

Source: Data analysis of NH Comprehensive Healthcare Information System (NHCHIS) completed by Center for Health Analytics, IHPP; Medicaid data year is January 2017-December 2017

Map recreated from https://www.dhhs.nh.gov/section-1115-waiver/documents/nh-dsrip-towns-by-idn-region.pdf



From a presentation at the Institute for Health Policy and Practice, UNH, delivered on June 26, 2019, by Jo Porter, MPH, Director, Institute for Health Policy and Practice and Lucy Hodder, Professor of Law, Director of Health Law and Policy, Franklin Pierce School of Law, Institute for Health Policy and Practice (page 8).

7. Provide financial results for the quarter ending December 31, 2019 for GraniteOne, CMCHS, MCH and HH.

See Attachment 3.

8. Provide financial results for the quarter ending December 31, 2019 for D-HH.

See Attachment 4.

9. Provide a copy of CMCHS and CMC's audited financial statement for fiscal year 2019.

See Attachments 5 and 6.

10. Provide a copy of MCH's audited financial statements for fiscal year 2019.

See Attachment 7.

11. Provide a copy of HH' s audited financial statements for fiscal year 2019.

See Attachment 8.

12. State the program service income and expenses for fiscal years 2017 through 2019 for Poisson Dental Center, Healthcare for the Homeless, and Amoskeag Health-McGregor, as well as CMC's financial contribution to same.

Healthcare for the Homeless/Community Health

	FY 2017*	FY 2018	FY 2019
Revenue and Contributions	$2,503,783	$2,352,925	$2,293,249
Expenses	3,279,976	2,674,702	2,699,435
Net Income (Loss)	($776,193)	($321,777)	($406,186)

Poisson Dental Center

	FY 2017*	FY 2018	FY 2019
Revenue and Contributions	$364,872	$273,250	$207,955
Expenses	849,398	698,849	657,531
Net Income (Loss)	($484,526)	($425,599)	($449,576)

*FY17 was CMC's change in fiscal year end. These figures represent 15 months of financial results.

Amoskeag Health

	FY 2017*	FY 2018	FY 2019
Contribution to Amoskeag for Rent	$78,180	$34,700	$31,430

**FY17 was CMC's change in fiscal year end. These figures represent 15 months of contribution. In addition, the first term of the agreement waived all base rents, while subsequent terms waive 50% of base rents.

13. Explain what obligations and advantages would apply to CMC, MCH or HH should they join the Dartmouth-Hitchcock Obligated Group (DHOG). How would they compare to benefits and burdens that currently apply arising from their current financing. Agreement Section 5.5.3.

Joining the DHOG offers CMC, MCH and HH the opportunity to refinance its existing debt at a higher rated obligated group at a lower interest rate resulting in significant net present

value savings. This can be done without having to amend or terminate existing swap arrangements which will enable the parties to gain the benefit of the lower rates without payment penalties or market adjustment payments. Based on May 2019 interest rates – which have gone down since increasing these benefits – Echo Financial Products, LLC estimates that refinancing existing CMC, MCH and HH debt would result in gross refunding savings of $6,844,918 translating to a net present value savings of $4,709,678 or an average annual cost of funds savings of $470,796 of savings in interest payments per year. *See Appendix IV(16) at pg. 7.*

The second benefit of joining DHOG is the lower cost of funds for the significant anticipated borrowing to fund the CMC hospital expansion (now called the Solinsky Center). DHOG offers two primary benefits to CMC with respect to the Solinsky Center. First, CMC would likely not be able to borrow the full $200 million for the project without impacting its current ratings which would increase the risk and cost of capital for the project. DHOG has the debt capacity to borrow the full amount needed for the project. Second, the cost of capital would be significantly less if borrowed through the DHOG rather than CMC's rating. DHOG currently has a rating of A/A. CMC had a rating of Moody's Baa1/S&P A-, however, S&P recently downgraded CMC to BBB+ with a "developing" outlook. The downgrade was attributed to recent financial challenges and increased competition in the Greater Manchester market. In the Echo illustration of these savings, the different ratings resulted in a gap in rates of 19 basis points resulting in a potential average annual debt service payment savings of $187,937. *See Appendix IV(16) at pg. 8.* Since this illustration was drafted, rates have fallen increasing the estimated benefit since estimated in May 2019. DHOG, for example, recently went to market with a new money financing and were able to borrow at 2.93% for a 40 year term. While market conditions can change, it is not anticipated that rates will increase significantly between now and when the building of the Solinsky Center will begin in April 2021.

14. If CMC, MCH and HH were to join the DHOG, would their current long term debt obligations are consolidated into those of DHOG? How will CMC, MCH and HH be assessed annually for obligations of DHOG? If the amount immediately will become greater than the debt obligations currently applicable to each entity, what is the justification for one entity's subsidy of another? Explain and calculate any countervailing financial benefits.

As described above, the advantages of joining the DHOG are achieved by consolidating long-term debt obligations of the DHOG members so that their credit worthiness is aggregated and a lower interest rate achieved. Although the obligations of the DHOG members are joint and several with respect to bondholders, each member remains responsible for its own indebtedness and there is no subsidizing of another entity's indebtedness or an additional cost for participating in the DHOG.

The DHOG makes all debt payments, on a consolidated basis, to note and bond holders. Internally, each prospective DHOG member will issue a promissory note to the DHOG for its respective long-term indebtedness. The DHOG then collects payments under the promissory

notes from its members and uses the funds to make payments to the note and bond holders. CMC's existing debt repayment will work similarly but within its existing Master Indenture Trust framework. The imposition and oversight of the Financial Principles by D-HHGO (*see* Combination Agreement Section 5.5.2(a) and (b)) is designed to ensure that each System Member, and thus each DHOG member, will be able to satisfy its long-term debt obligations without the need for subsidy.

15. What will be the sources of the $200 million funding needed for CMC to expand its hospital facility in Manchester, should the transaction close? Is D-HHGO participation contingent upon CMC joining the DHOG? Agreement Section 5.5.5.

If the Combination is approved, we currently anticipate that the CMC Expansion Project will be funded through a combination of debt and equity. Subject to market conditions, we expect to issue approximately $150 million in tax-exempt bonds through the DHOG and fund the balance of the Project through a combination of philanthropy and existing equity (i.e. cash).

Although we anticipate that CMC will join the DHOG, D-HH GO's participation in the CMC Expansion Project is not contingent upon the occurrence of that event. D-HH's participation in the CMC Expansion Project, however, will occur only if the transaction is approved and is consummated.

16. Is the contemplated annual financing savings of $188,000 related to the CMC expansion project separate from the annual financing savings of $470,000 for CMC, MCH and HH collectively, should the parties join the DHOG? How does that compare with the PYA Cost of Capital Savings? Echo Financial Products Report, pp. 7-8.

The annual financing savings of $188,000 related to the CMC expansion project is separate from the annual financing savings of $470,000 that is estimated to result from the refinancing of CMC, Huggins and Monadnock existing debt. Total annual savings related to refinancing existing debt and borrowing at the lower cost of capital afforded by the DHOG would exceed $650,000 per year. These two calculations are detailed on pages 7 and 8 in The Acquisition Funding Refinancing Opportunities Report by Echo Financial Products, LLC. *See Appendix IV(16)*. These savings are conservative for two reasons. First, as set forth on page 8 of the report, the estimated savings of $188,000 was calculated based upon a new borrowing of $150 million. The Solinsky Center (CMC hospital expansion) is anticipated to cost $200 million so the actual savings is more likely to be in excess of $240,000. Second, the savings calculation was calculated on May 7, 2019. Since then, interest rates have dropped a number of basis points. DHOG recently completed an offering at 2.93% which is lower than the 3.03% rate assumed in the May 2019 analysis. While market conditions can go the other direction lowering anticipated benefits, most economists do not anticipate a significant swing in interest rates over the anticipated period of the refinancing and hospital expansion borrowing.

The PYA capital savings and the Echo savings are the same. The Echo estimation was used by PYA.

17. Describe the likely size of the fee to be assessed against CMC, MCH and HH by D-HHGO for group purchasing, information technology and shared corporate services, and how will it be calculated? Agreement Section 3.4. l(b)(iv).

To date, D-HH has not assessed fees for group purchasing, information technology or shared corporate services, while GraniteOne has made some assessment for shared services. As services such as these become centralized over time in the D-HH GO System, we anticipate that actual costs incurred will be allocated and charged back to individual D-HH GO members based upon a reasonable allocation methodology and metrics. For example, fees for these services could be calculated by aggregating the total cost of the allocable costs and allocated as a function of a pro rata portion of revenue or expenses and actual use of such expenses. For illustration, if the System incurs a cost of $10,000,000 for a corporate service and CMC utilizes those services to the full extent, CMC would pay D-HH GO a portion of the $10,000,000 equal to the ratio of CMC net patient revenue to the total patient revenue of the D-HH GO System.

18. To what use of D-HHGO may the unrestricted fund balances of CMC, MCH and HH be placed following the transaction?

D-HHGO's reallocation of the unrestricted fund balances of CMC, MCH and HH is governed by Section 5.5.2(c) of the Combination Agreement. The funds may be reallocated only for one or more System purposes which are in furtherance of the System Strategic Plan. The board of trustees of each member organization within each of the D-HH System and the GraniteOne Health System have determined that the support of, and participation in, an integrated health care delivery system is the most appropriate manner in which to carry out their fiduciary obligations to further the organization's charitable mission and to serve as stewards of its charitable assets. Therefore, each organization's unrestricted assets may be used but only to the extent that it is serving a System purpose and strategy that is designed to strengthen the System as a whole and thus benefit all members. Although the System Strategic Plan will not be developed until the Combination is approved and consummated, System's purposes could include the construction and operation of a centrally-located pharmacy and supply chain warehouse to take advantage of bulk purchasing, the costs of which would be allocated to System Members pro rata based on anticipated or actual use.

After a System purpose has been identified, the D-HHGO Board then must determine that a reallocation of unrestricted funds (i) is the most appropriate way in which to fund the System program or initiative; (ii) will not materially impair the ability of any System Member to continue to serve the health needs of the communities it serves or to meet its debt obligations; and (iii) is consistent with the System Member's compliance with the System Financial Principles. In other words, the funds to be reallocated must be excess funds not needed for the current obligations of the System Member and thus available for support of the System.

As a further protection, the D-HHGO Board must follow the process outlined in Section 5.5.2(c) of the Combination Agreement involving the System Member CEO and board of trustees, the System Board Chair, the System CEO and the Regional President. Regardless of the System Board's determinations, it may never reallocate funds if the reallocation would result in a default or breach of the Member's debt obligations or a reduction in its bond rating. Furthermore, any proposed reallocation of the unrestricted assets of CMC or any CMCHS Subsidiary is subject to the Bishop's Reserved Powers, and may never be re-allocated to fund or implement a procedure that is inconsistent with Catholic moral teaching, the ERDs or Canon Law. Although the DHMC patient tower and CMC Expansion Project have been developed before the preparation of a D-HHGO System Strategic Plan and the unrestricted assets of MCH and HH would not be re-allocated for such purposes, MCH and HH negotiated an express provision to that effect at the end of Section 5.2.2(c) of the Combination Agreement.

All of the foregoing protections will be "hard-wired" in the revised post-transaction governance documents of the System Members.

19. Explain the significance if D-HHGO will become a "controlled group" following the transaction. Explain whether the use of the term "Combination" in the title of the Agreement means that FASB ASC 958-805 on combinations will apply and if so whether the transaction will be accounted for as an acquisition or merger.

All organizations within the same "controlled group" as defined in Sections 414 (b) and (c) of the Internal Revenue Code of 1986, as amended (the "Code") ("Controlled Group"), are treated as a single employer for purposes of several important Code and ERISA requirements as applied to the employee benefit plans of the Controlled Group members. If D-HHGO is a Controlled Group (the "D-HHGO Controlled Group"), the following consequences will result:

(i) First, in the event of a distress termination of the CMC Pension Plan or any other defined benefit plan of the D-HH GO System members, the Pension Benefit Guaranty Corporation (PBGC) can look to any or all members of the D-HHGO Controlled Group for contribution.

(ii) Second, in order to maintain the "qualified" status of Code Section 401(a) and 403(b) qualified retirement plans of the D-HHGO Controlled Group members, all Code requirements must be met on a Controlled Group basis, including, but not limited to, nondiscrimination and coverage testing. The failure to meet these requirements on a Controlled Group basis potentially can result in significant operational failures, correction penalties or plan disqualification.

(iii) Third, Code and ERISA requirements that are applicable to welfare benefit plans must also be applied on a Controlled Group basis, including non-discrimination rules applicable to self-insured health plans.

The Parties anticipate that FASB ASC 958-805 will apply to this transaction. However, as structured, an assessment by the parties' independent public accountants will be required to determine how ASC 958-805 (previous FASB Statement #164) will be applied. The principles within that accounting guidance distinguishing an acquisition from a merger are complex, and will ultimately require careful and thorough consideration of all terms of the combination, and an assessment by the independent audit firm. The parties will be including this assessment as part of their integration planning.

20. Provide the hospital-by-hospital estimates developed by the Rural Hospital Subgroup in May, 2019 for the cost savings that the D-HH and GO critical access hospitals have achieved after becoming part of a larger system.

See Attachment 9 for a subset of the cost savings identified by the Rural Hospital Subgroup.

21. State CMC's annual payments toward the CMC Pension Plan for fiscal years 2015 - 2019, and the Plan's funded status at the end of each fiscal year. GO 2018 Combined Financial Statements, Note 8.

The following summarizes the annual payments made towards the CMC pension plan for fiscal years 2015 through 2019:

	FY15	FY16	FY17	FY18	FY19
Contributions	$ 10,000,000	$ -	$ -	$ 403,125	$ 8,141,191
Funding Status					
Obligation	250,014,863	285,649,322	284,200,778	270,114,507	322,354,937
FV of Plan Assets	178,653,038	164,351,991	181,485,201	185,414,590	189,347,537
Funded Status %	71%	58%	64%	69%	59%

CMC has approximately $10,000,000 of "credits" recognized by the Internal Revenue Service that have accumulated based on historical funding contributions made by CMC to the plan which exceeded the required funding amounts. These credits from past years can be used to reduce the contribution requirements in future years. CMC plans to apply them against contribution requirements for the June 30, 2020 and June 30, 2021 plan years.

Note: The decrease in funding status from fiscal years 2018 and 2019 is the result of reductions in market interest rates which in turn reduced the actuarial discount rate by 1.11% resulting in an increase in long-term funding obligation values of $50,000,000.

22. State the reason for MCH's operating loss of $1.8 million in fiscal year 2018.

MCH did not have an operating loss of $1.8 million in fiscal year 2018. Pursuant to the Audited Financial Statements, Statements of Operations for the year ended September 30, 2018, MCH reported operating income of $329,628. *See Appendix III(26).*

23. Provide any auditor's management letters to CMC, MCH or HH for fiscal years 2018 and 2019.

CMC:

CMC did not receive a management letter for fiscal years 2018 and 2019. Provided at *Attachments 10* and *11* are the "Best Practices Letter" and the "No Material Weakness Internal Control Letter" for the recent 2019 audit.

MCH:

MCH did not receive a management letter for fiscal years 2018 and 2019.

HH:

HH did not receive a management letter for fiscal year 2018. A management was received for fiscal year 2019 and is included as *Attachment 11*.

24. State the reasons for CMCHS's negative net margin for fiscal year 2019 and the substantial increase in its pension liability for fiscal year 2019.

CMCHS had an operating loss in fiscal year 2019 and through the first quarter of fiscal year 2020. The financial challenges are the result of below budget volume stemming from issues with average length of stay, process efficiencies, and patient flow that prevented the organization from accepting almost 1,000 referrals primarily from its transfer center during fiscal year 2019. Other factors contributing to the loss include the need to use expensive temporary labor and overtime expenses due to recruitment and retention difficulties and workforce challenges, the loss of four high performing proceduralists who left the organization or retired. CMCHS also continues to lose market share to in and out-of-state competitors, particularly in orthopedics and surgery. CMCHS also began the process of implementing a new electronic medical record resulting in downtime, revenue loss and additional conversion costs.

CMCHS has budgeted for a $4.1 million operating loss for fiscal year 2020. Management is working with consultants on an operational improvement plan and expects to see financial improvements from those efforts beginning towards the end of the second quarter of fiscal year 2020 through the end of fiscal 2022. As set forth in great detail in the Combination Agreement, the Joint Notice and supporting documents, the Proposed Combination and the

initiatives focused towards improving CMCHS' capacity capabilities and expanding specialty services will enable CMCHS to compete in the heavily competitive southern market of New Hampshire and in particular meet the needs of New Hampshire patients seeking care out-of-state unnecessarily.

The increase in the pension funding liability from fiscal years 2018 and 2019 is the result of reductions in market interest rates which in turn reduced the actuarial discount rate by 1.11% resulting in an increase in long-term funding obligation values of $50,000,000.

25. Explain the statements in the D-HH 2019 audited financial statements at Note 9 that the board of directors of D-HH interprets UPMIFA "as requiring the preservation of the original value of the gifts", and that donor restrictions are limited to the original value of gifts.

The second paragraph of Note 9 to the audited consolidated financial statements of D-HH for fiscal year 2019 describe only the manner in which "historic dollar value" is calculated for purposes of compliance with New Hampshire RSA 292-B:4(V). The third paragraph of Note 9 then states that "any retained income and appreciation on donor-restricted endowment funds" continue to be restricted until appropriate and expended for a qualified use. Although the retained income and appreciation of donor-restricted endowment funds was recorded as "temporarily restricted" in the 2019 consolidated financials (perhaps incorrectly), a change in accounting standards will require the retained income and appreciation to be booked as "restricted" until appropriated and expended for a qualified expense.

The D-HH policy appended in response to Question 26 below better describes the process followed by D-HH with respect to the investment, accumulation and expenditure of its donor-restricted funds.

26. Provide the spending policy applicable to D-HH's donor restricted funds. State how D-HH accounts for appreciation in donor restricted funds in excess of amounts not appropriated but rather accumulated in a given year.

See Attachment 12.

Section IV(B)(i) of the attached Endowment Fund Policy states that D-H may appropriate for expenditure or accumulate donor-restricted funds, subject to the intent of the donor and the standards established under the Policy and by UPMIFA. That section of the Policy then expressly states that "the assets in the endowment fund are donor-restricted assets until appropriated for expenditure by the institution." Therefore, any accumulated earnings on D-H donor-restricted funds which are not appropriated for expenditure in a given year remain restricted until and unless appropriated in a subsequent year.

27. State whether the restatement of donor restricted funds undertaken in 2016 as part of the GO transaction is reflected in the current financial statements of CMC, MCH and HH. List the historic dollar value and appreciated market value of those funds and their restricted status for both accounting purposes and UPMIFA as of the end of fiscal 2019.

CMC:

The George E. Trudel Fund (the "Trudel Fund") was the only fund that required re-establishment as part of the GraniteOne affiliation. The Trudel Fund was bequeathed to Notre Dame Hospital in 1950 under the will of George E. Trudel: $15,000 in trust, the "income to be used for the purposes of the hospital." CMC became the trustee of the Trudel Fund upon the merger of Sacred Heart Hospital and Notre Dame Hospital in 1974. The Trudel Fund was reestablished as a permanently restricted fund at the value of $58,883.81 in January 2017. It remains on the books as a permanently restricted asset and has a current appreciated value of $76,169.63. The restatement of funds as part of the GO transaction is reflected in the current financial statements of CMC.

MCH:

The restatement of funds as part of the GO transaction is reflected in the current financial statements of MCH. *See Attachment 13A* showing the historic dollar value, appreciated market value and spending per UPMIFA as of September 30, 2019.

HH:

HH did not need to restate any of restricted funds in connection with the GraniteOne affiliation. *See Attachment 13B* showing the historic dollar value, appreciated market value and spending per UPMIFA as of September 30, 2019.

CLINICAL SERVICES AND MANAGEMENT

28. Identify admission yields and GMAT scores from 2009-2019 for incoming classes at Dartmouth Geisel School of Medicine and compare them with the comparable national averages. Provide competitiveness data from 2009-2019 as to incoming classes for graduate medical education at D-HH.

Dartmouth College's Geisel School of Medicine has no direct corporate or governance relationship with D-HH, so D-HH does not have easy access to historical data on admissions yield and MCAT scores. Competitiveness of the Dartmouth-Hitchcock Medical Center (DHMC) graduate medical education classes is based primarily on whether it is able to match the students it wants with their desire to come to us. The challenges DHMC faces, given the demographics in the rural region surrounding it, is providing the optimal teaching experience for students and residents which requires sufficient volume and acuity of patients. Many students and resident need to spend a portion of their time out-of-state to obtain those

experiences. In addition, it is difficult to find jobs for students' spouses in the Upper Valley. These factors are dissatisfying for students and residents. Through the proposed transaction DHMC will be able offer more teaching sites and a greater diversity of patient populations, particularly in Manchester, that will enhance the opportunity for students and residents to learn and train closer to DHMC and Geisel and in a more urban setting. Without the proposed transaction, the lack of population growth and aging population surrounding DHMC will make it increasingly difficult to continue to attract the same level and quality of students and residents.

29. Explain how CMC has identified high-acuity oncology, orthopedics, complex trauma, and spine surgery as priority areas for expansion. Identify any studies showing which high-acuity services are in the shortest supply in southern New Hampshire. Chartis Report.

In assessing where to prioritize expansion efforts, CMC is striving to be better positioned to care for patients leaving SNH for MA hospitals while simultaneously preparing to accommodate the wave of future demand driven by an aging population.

As described in detail in the D-HH GO Clinical Integration Strategy, the aging of the SNH population will drive major growth in demand for orthopedic and spine care in both inpatient and outpatient settings. Over the next decade, the demand for spine and pain care in SNH is expected to grow by 2.3% for inpatient care and 31% for outpatient care[1]; similarly, the need for orthopedics care in SNH is projected to increase by 7% for inpatient care and 29% for outpatient care[2].

Additionally, a strong trauma program is essential for CMC's goal to appropriately address the needs of the community. Accidents are the third leading cause of death in NH, and the state's accident mortality rate (66.6 per 100,000 people) is the fourth highest in the nation.[3]

Expanding CMC's ability to care for high-acuity oncology services locally is critical for both patients and families. Not only is cancer the leading cause of death in the state, it affects SNH disproportionately; residents of Rockingham and Merrimack counties have cancer mortality rates above the state average[4, 5]

The abovementioned surgical services are all hallmarks of strong tertiary community hospitals. Currently, CMC's service mix is disproportionately weighted towards its marquee heart and vascular program. Enhancing and expanding these services will allow CMC to more effectively compete for referrals that are leaving SNH for MA hospitals. CMC currently does not have the capacity to answer patient demand for these services even before the anticipated wave of demand in the coming decades. After heart and vascular care,

[1] Advisory Board projections, 2017
[2] Ibid.
[3] CDC, 2016
[4] Ibid.
[5] NH Dept. of Health and Human Services, Wisdom Tool (2011-2015)

oncology, orthopedics, trauma, and spine surgery represent the four largest single services departing the state for Massachusetts hospitals, approaching one-third of all care leaving the region.[6] By preparing now to address these looming demands, CMC will help to ensure SNH residents can receive the highest levels of care closer to home.

30. Explain which high-demand service lines CMC has not been able to supply to HH and MCH since their affiliation in 2017.

Both HH and MCH would like to maintain a basic level of specialty services and are working to shore up what they have previously provided and to add others. The needs of each hospital are somewhat different.

MCH:

Both General Surgery and Orthopedics are services that MCH has provided locally for many years.

MCH requested assistance in General Surgery from CMC and began to have some additional coverage in 2017 and 2018 with a couple of days per month coverage from general surgeons and a vascular surgeon. In October, 2018, MCH requested support for a half time general surgeon which initially started out as three days per week, however, due to needs at CMC, ended up as 2 days per week at MCH (Mondays and Wednesdays with a day off in between). This general surgeon was eliminated at CMC as of April 2019 and since then CMC has been unable to provide a general surgeon to MCH due to its own needs. Since October 2018, MCH has been working to recruit its own employed full time general surgeon and has been using locum coverage. The part time surgeon from CMC did not support call coverage to MCH's Emergency Room for general surgery on a consistent basis. One of the challenges in a small community with limited physicians is the difficulty covering emergency room call 24/7 (365).

Regarding Orthopedics, MCH has a group identified as an orthopedic practice but it is actually a hybrid that currently includes only one full time and one part time surgeon and two Physician Assistants. CMC does not employ orthopedic surgeons, but instead worked with New Hampshire Orthopedics. MCH negotiated a one day per week provider from NHOC directly and a hand surgeon twice a month. This approach became unsustainable, as the service did not provide any emergency room call coverage. Like general surgery, MCH has had difficulty trying to recruit orthopedic providers in part because of the need to provide emergency room call coverage.

Despite multiple requests for pulmonary specialist support on site a couple of days per week, MCH has not had a pulmonary specialist available except to remotely read the pulmonary function tests done at MCH. In fact most recently, CMC cancelled the reading of the pulmonary function tests because the pulmonologist who was planning on assisted departed

[6] Extract of Massachusetts CHIA data, FY2016 and FY2017. Note that extracts of CHIA data omit all records with fewer than 11 discharges. While this report was aggregated to minimize the impact to the totals, the actual amounts are likely higher than presented in the response.

from CMC to work at a Massachusetts hospital. MCH is currently working to have the pulmonologists credentialed from D-HH so that the PFT tests can be read remotely.

MCH had a full time neurologist who was underutilized. Since CMC was looking for a neurologist to assist with some of its inpatient needs, MCH worked with CMC to employ the neurologist and lease the clinician back to MCH two or three days per week to provide services in the MCH community. The neurologist left employment at CMC and MCH does not have sufficient volume to employ a physician full time. Thus there is currently no coverage for neurology at MCH except for tele-stroke neurology which is a more emergent kind of system.

Finally, MCH had the opportunity to hire a rheumatologist and worked with CMC to hire this individual who worked three days in Peterborough and two days in Manchester. In 2019 he decided to leave and open his own practice, leaving MCH with no rheumatologist. CMC does not have the ability to cover this service for MCH patients.

HH:

CMC has helped to provide some Gastroenterology coverage but, due to a need at CMC, the service was removed at HH. Most recently, the service has restarted at HH at 50% of the initial coverage agreement. Referral data suggests that HH could use more coverage than what was initially implemented between CMC and HH but more coverage is currently not available from CMC.

HH has had meetings with CMC to bring pre and post-operative services for Bariatric patients to HH but neither organization currently has the staffing and space for the service.

HH has had some limited discussions with CMC and one of the CMC surgeons regarding expansion of their Breast Health program to HH but this has not yet moved forward.

As part of the affiliation in 2017, it was a priority for HH to partner with CMC for management of the Hospitalist program and staff. To date, CMC has provided physicians to cover some of HH's immediate needs which provides some stability and has reduced HH's expenses. HH is still working with CMC and considering the need for an outside vendor, TeamHealth, to provide Hospitalist program management due to resource limitations.

At the time of affiliation, HH was struggling with staffing the Emergency Department providers. HH was using a small local group that staffed HH and Lakes Region Healthcare. CMC was looking for a new vendor as well, and HH hoped to get proposals with CMC and select a vendor for both hospitals. CMC selected a vendor that was not interested in HH. HH was eventually able to secure a new agreement with TeamHealth separately.

HH had hoped to reach an agreement with the same Radiologist vendor used by MCH and CMC; however, HH was not able to negotiate a reasonable agreement with that vendor. HH has reached an agreement with D-HH that begins on July 1, 2020.

HH did not work directly with CMC regarding Anesthesiology needs; however, HH did get a proposal from CMC's current vendor. The CMC vendor provided HH with a reasonable proposal, but HH selected a different vendor that was a better fit.

HH had one independently employed physician providing Ophthalmology services until he retired a few years ago. CMC does not employ ophthalmologists; however, it tried to help HH make a connection with a Manchester group. This was not successful, and HH has not been successful in its independent recruitment efforts.

HH currently does not provide any cancer treatment services yet the community has a high rate of cancer deaths and a need for local treatment. It is very difficult, if not impossible, to recruit a part-time Oncologist, and HH has not attempted to move forward with service as part of the GOH affiliation. HH hopes to move forward with building this service as part of the combination between GOH and D-HH.

31. Describe the contemplated increased staffing at CMC, MHC and HH that will be hired to implement the behavioral health Strategic Priorities #1 through #4? How will those positions be filled? Agreement Section 5.3.2(a). Chartis Group, Clinical Integration Strategy.

See response to Question 35.

32. Explain whether the behavioral health Strategic Priority #3 will result in increased behavioral health emergency department bed capacity at CMC, MCH or HH.

See response to Question 35.

33. Given the recognition of the need for increased behavioral health services, explain the lack of a plan by D-HHGO to increase inpatient psychiatric beds beyond the 21 at D-HH's facilities. Agreement Section 5.3.2(a), New Hampshire IO-Year Mental Health Plan, p. 43 (2019).

See response to Question 35.

34. Explain the feasibility for D-HHGO to develop alternative sites for care away from emergency rooms, including the use of behavioral health beds. Chartis Report, p. 16.

See response to Question 35.

35. Describe how if at all how the plan for increased behavioral health services will use or increase the capacity of Mental Health Center of Greater Manchester?

The following is a response to Questions 31-35 collectively:

The Parties have undertaken a methodical approach to identify those high priority community needs on which their combined clinical services would have the most immediate impact. Through a process led by a "Clinical Integration Strategy" workgroup comprised of clinical and administrative leaders from both organizations, behavioral health care emerged as a top priority. A "Behavioral Health Clinical Opportunities" subgroup was constituted and charged with identifying the initiatives that would comprise the Parties' preliminary behavioral health strategy. That subgroup formed the basis for what became the "Behavioral Health Planning Steering Committee" (the "Committee") comprised of clinical and administrative leaders and internal stakeholders from both organizations, as well as external stakeholders, including the Mayor of Manchester, the Governor's Advisor on Addiction and Behavioral Health, the Mental Health Center of Greater Manchester, the City of Manchester Health Department, and Granite United Way, among others.

Guided by the "New Hampshire 10-Year Mental Health Plan" (the "Plan") and input from stakeholders, the Committee developed a patient-centered behavioral health care program that spans the primary care, outpatient and hospital-based continuum of care. The program consists of six strategic priorities: 1) Addiction Treatment Services; 2) Integrated Behavioral Health in Primary Care; 3) Crisis Emergency Department Services; 4) Behavioral Intervention for Hospital Inpatients; 5) General and Specialty Outpatient Psychiatry; and 6) Interventional Psychiatry, all of which will be supported by foundational infrastructure in tele-psychiatry and behavioral health workforce development. This program has been developed to conform to the Plan's call for "strategic investments" to eliminate inequities in access to care and offer New Hampshire's citizens a coordinated continuum of high quality services. *See* Plan at 12.

The program does not propose an increase in inpatient psychiatric beds (**Question 33**) because, as the Plan recognizes, "[p]sychiatric hospitalization is the treatment setting of last resort for individuals whose mental illness is so acute or severe that they are in danger of harming themselves or others." *See* Plan at 29. Although "[t]he problem of ED wait times [for psychiatric hospitalization] is a recent phenomenon in NH and attention is now focused on it … too much of our current inpatient capacity is occupied by patients who might be able to be effectively treated in less restrictive and more economical environments." *See* Plan at 9, 12. Accordingly, the Parties' proposed strategic investments aim to "enhance services that divert avoidable hospitalizations, support transitions to the community, reduce readmissions, and facilitate outflow from inpatient settings." *See* Plan at 29. Moreover, the State's declared plan to reallocate capacity at New Hampshire Hospital by moving children to Hampstead Hospital will allow for up to 48 new adult beds to accommodate the average of 38 adults per day waiting in hospital EDs for admission to inpatient psychiatric treatment. *See* Plan at 9.

The Parties' Strategic Priority #3 (Crisis ED services) does not contemplate increased behavioral health emergency department bed capacity (**Question 32**). On the contrary, a primary goal of the Parties' program is to obviate the need for more behavioral health emergency department beds. As the Plan recognizes, "EDs are not intended to serve as long-term waiting spaces." *See* Plan at 9. The ED is an inhospitable, nontherapeutic environment for a behavioral health patient, whose condition can decompensate quickly, leading to a longer length of stay either in the ED or in the hospital inpatient setting, a poorer outcome, and less engagement with treatment. Early behavioral health intervention through Crisis ED services supported by tele-psychiatry will facilitate better management, timely treatment, and early discharge of behavioral health patients from the ED, expanding capacity for non-behavioral health patients presenting with emergency medical or surgical needs.

CMC has developed a model program for identifying eligible patients and implementing MAT in its ED, with associated benefits in improved patient experience and engagement in treatment, reduced recidivism, and reduced reliance on overburdened inpatient addiction treatment services. D-HH oversees a tele-psychiatry service that provides on-demand psychiatric assessment and care management consultation to ten hospital EDs in New Hampshire, with MCH coming online in March. A combined, comprehensive, technology-driven tele-psychiatry service is the most effective, efficient way to bring this expertise to complex mental health-related cases in the EDs at CMC, MCH and HH, especially given the dearth of providers in NH. A combined D-HH GO Crisis ED program will bring a cascade of benefits to both patients and providers. Patients will receive the specialized care they need, which can avoid unnecessary hospitalization and expedite their disposition or discharge, improving their experience and outcome, and reducing disruptive patient conduct that places ED staff in harm's way.

The Parties' strategic investments in primary care integration and outpatient services are consistent with the trend toward "outward models" that increase access to care in the community and minimize demand for hospital services through prevention and follow-up care at the local level. *See* Plan at 15. The Parties anticipate that their program will reduce the demand for behavioral health beds and, accordingly, they have not examined the feasibility of developing alternative sites of care in the short-term (**Question 34**). The feasibility of such alternative sites of care over the long-term will be influenced by the success of the Parties' strategic priorities assessed over time and may become part of the outward model approach.

The Parties' programmatic investments will require an estimated total of 18 behavioral health providers and clinicians in the primary care, outpatient, and emergency department settings at CMC, MCH, and HH. Fully staffed programs will include 3.2 psychiatrist FTEs, 7.6 LCSW FTEs, and 7.3 APRN FTEs, which the Parties expect to achieve over a 5-year implementation timeline. These estimates will continue to evolve as business planning matures but the Parties anticipate increased workforce needs to implement Strategic Priorities #1 through #4 (**Question 31**) specifically, as follows:

Strategic Priority #1: Addiction Treatment Services

Through ongoing study and due diligence, the Parties have determined that addiction treatment services are, and will continue to be, most acutely needed in southern New Hampshire and Greater Manchester in particular. This determination is reinforced by CMC's anticipated replacement of Granite Pathways as the "Doorway" for the Manchester region, which will serve as a platform for replicating D-HH's multi-disciplinary program while augmenting CMC's existing offerings.

The Parties' proposed addiction medicine program will consist of three components: (1) an intensive outpatient program (IOP); (2) a medication assisted treatment program (MAT) with individual substance use disorder (SUD) counseling; and (3) an addiction medicine fellowship. The Parties have developed a preliminary staffing model for each component.

The IOP program assumes group counseling cohorts of 10 patients, and for every two such 10-member groups the preliminary staffing model contemplates the need for 1.5 licensed clinical social worker (LCSW) FTE, e.g., four 10-member groups will require 3.0 LCSW FTE, etc.

The preliminary staffing model for the MAT and SUD program contemplates the need for 0.2 psychiatrists FTE to perform the initial medical/medication evaluation, 1.0 APRN to manage the MAT program, 1.0 LADAC to provide individual counseling services, and 1.0 LNA to monitor vitals, coordinate drug screening, and obtain prior authorizations.

The addiction medicine fellowship contemplates the addition of 2 fellows per year.

Strategic Priority #2: Integrated Behavioral Health in Primary Care ("Collaborative Care")

The Parties anticipate deploying the Collaborative Care model across their largest PCP sites of service (i.e., at least 12 sites) over the next five years in order to improve access, patient outcomes, and lower the total cost of care. The preliminary staffing model assumes that for every 10,000 patients the System will require 1.0 LCSW FTE, 0.1 consulting psychiatrist FTE, and .07 administrators FTE. The Parties also anticipate wider use of tele-psychiatry to support the provision of Collaborative Care across the System.

Strategic Priority #3: Crisis Emergency Department Services ("Crisis-ED")

The Parties anticipate implementing or expanding Crisis-ED services at all System hospitals over a three year period. The preliminary staffing model assumes that for every 6 ED beds with patients requiring psychiatric evaluation the System will require 0.3 psychiatrist or APRN FTE to perform the initial medical/medication evaluation and 1.0 LCSW FTE to monitor and provide ongoing care. The Parties also anticipate wider use of tele-psychiatry to support the provision of Crisis-ED services across the System.

Strategic Priority #4: Behavioral Intervention for Hospital Inpatients ("Consult Liaison" program)

The Parties anticipate implementing the Consult Liaison program in inpatient medical and surgical units at each System hospital over a five-year period. The preliminary staffing model assumes that for every 300 beds the System will require 0.5 psychiatrists FTE, 1.5 APRN FTE, and 4 LCSW FTE. The Parties also anticipate wider use of tele-psychiatry to support the provision of Consult Liaison services across all System hospitals.

The Parties have identified growth of the behavioral health care workforce as one of two foundational initiatives on which the success of the strategic priorities above depends. The combined System will initiate the recruiting process for needed providers and clinicians immediately upon closing the transaction with a view to building fully staffed programs over five years (**Question 31**). Initial recruitment will focus on prescribing positions, i.e. psychiatrists and APRNs, followed by master's level clinician team support. The Parties are discussing various ways to incentivize pursuit of behavioral health degree programs and licensure, including scholarships and tuition prepayment programs. Given that CMC, MCH, and HH sites will require fewer than 1.0 FTEs for some strategic priorities, the System will divide provider time across sites via tele-psychiatry, use of regional travel models, or by allocating provider time and service(s) at one site. Additionally, the Parties will continue to build on their academic affiliations with Manchester Community College, Granite State College and the University of New Hampshire to establish a stable, home grown health care workforce, as Dartmouth-Hitchcock recently did by providing seed money for Colby-Sawyer to begin offering baccalaureate programs in addiction studies and mental health counseling, among other health care-related programs.

The Parties believe that combining to expand the reach of their respective workforce development efforts, e.g., D-HH's "Workforce Readiness Institute" and CMC's "Transition to Professional Practice" program, will enable them to train, recruit, retain and develop the necessary staff for their new and expanded addiction treatment, Collaborative Care, Crisis-ED, Consult-Liaison and other behavioral health services. *See* Combination Agreement at Article I, section 1.6 (addressing workforce needs as one of the purposes of the Combination).

In order to implement their strategic priorities and recruit the necessary workforce the Parties expect to incur costs in excess of $20 million over 5 years and operate the behavioral health program at a financial loss.

CMC has been and will continue to be a partner and supportive of the Mental Health Center of Greater Manchester (the "MHCGM") (**Question 35**). While the combined System's behavioral health program does not directly address the MHCGM, we expect that the following will have the potential to positively impact capacity at MHCGM:

- As discussed above, the Parties' Crisis-ED services at CMC in Manchester, which will combine tele-psychiatry services from D-HH with medication management from CMC

for psychiatric patients boarding in the emergency department, is aimed at reducing the number of patients waiting for a bed at New Hampshire Hospital, support transitions to the community, and facilitate outflow from inpatient settings. If, as the Parties expect, this strategic priority is successful, there will be a need for increased community-based mental health services that are typically provided by the MHCGM;

- As discussed above, one of the foundational initiatives of the Parties' program is focused on workforce development, including the use of D-HH psychiatric residents at CMC. Any new workforce introduced to the community as a result of the Proposed Combination should benefit the MHCGM. For example, given the long wait times for services from the MHCGM, the Proposed Combination could potentially augment the services of the MHCGM by adding capacity at CMC without negatively impacting the MHCGM or taking their patients; and

- Finally, as the Parties expand their care for inpatients and identify those who have behavioral health issue co-morbidities, the MHCGM would continue to be a resource for community-based care upon discharge and the Parties will continue to partner with the MHCGM to ensure those patient needs are met.

36. How did MCH and HH determine the clinical and specialty services that each stated as requested commitments from D-HHGO? How might that change in light of the D-HHGO strategic plan to be prepared within one year of the transaction? Agreement Section 5.3.4, 5.1.1.

Overall, both rural communities have seen a gradual loss of access to specialty services. Patients are required to travel further for care as a result, and local primary care physicians have limited access to specialists to assist them with the care of their patients.
The hospitals' requests were based on their Community Health Needs Assessments, strategic plan priorities, current volumes and the importance of the service to the stability of the hospital.

Both hospitals have provided a basic level of specialty access in general surgery and orthopedic surgery locally for many years, and both services are important to the community for their support of each emergency department. General and Orthopedic surgeries are two of the few services that typically generate a positive margin for each hospital when they are fully utilized. The margin in these areas provides significant financial support to all the services that do not have positive margins and enable each hospital to provide millions of dollars in Community Benefits each year. But, the full utilization of these services is jeopardized, because recruiting and retaining providers to a small rural hospital for these service lines has become extremely difficult. One of the challenges is call coverage obligations which are generally 1 of 2 providers, or 1 in 2 call. MCH has been recruiting for a full time general surgeon for 17 months. Similarly, it has a need for two full time orthopedic surgeons but has been covering orthopedics with 1 FTE surgeon (essentially two part time providers) and some physician assistants. MCH believes it is important to continue to provide these services to its community and is looking for assistance for recruitment and

call coverage. Without call coverage regularly, MCH is forced to send patients to other hospitals resulting in underutilization of its operating rooms. In addition, the patients may not go to hospitals in NH due to a lack of available beds in other New Hampshire hospitals. HH is currently fully-staffed in both specialties; however, it recognizes that it will need the support of D-HHGO at some point to help with staffing. The financial integration of the D-HHGO combination could make it feasible to rotate orthopedic and general surgeons to provide the coverage needed at all three GOH locations.

Both hospitals have a need for urology specialty services that are aligned with their mission to provide services to the population in their service areas in a location that is accessible, especially for the aging population in each service area. Travel for patients of both hospitals can be challenging based upon the age demographic and geography of each. Both areas lack any form of public transportation requiring many patients to rely on a Volunteer Transportation Organization for support. MCH lost a two day per week urologist who came from Cheshire in Keene in 2018 and the position has not been replaced. A part-time physician from Lakes Region General Hospital and a part-time physician from Concord Hospital currently provide urology services at HH. Since HH is not currently aligned with either hospital there is a tendency for these physicians to send patients they see at HH to other hospitals for services that could be provided more conveniently at HH.

MCH has an oncology and infusion therapy center on its campus with services provided by Cheshire in Keene. The Medical Director retired in August and has not been replaced. A second oncologist is also planning to retire in the near future. Without support, MCH will not have enough physician support to see oncology patients in the community, and they will be forced to travel. As noted in question #30, HH currently is not providing any cancer treatment services. The data gathered for HH's Community Health Needs Assessment noted that the cancer incidence rate for Carroll County is at 450.0 per 100,000 which is lower than the New Hampshire rate at 479.7 however the cancer death rate in Carroll County, at 157.9, is higher than the New Hampshire rate at 153.5. Access to cancer treatment is a priority for HH's community.

MCH has a Behavioral Health practice that serves the community. It has recently contracted with D-HH for tele-health support for psychiatry because of turnover in its Behavioral Health practice that it is trying to replace. Based on HH's recent Community Health Needs Assessment data, Carroll County had the same average number of poor mental health days as New Hampshire and was higher than the national average. Behavioral Health continues to be an issue for all of New Hampshire and compounding the crisis is a severe shortage of healthcare professionals. HH has struggled to hire staff and tele-health services are currently cost-prohibitive.

As noted in Question 30 (hereinbefore), HH is currently not providing ophthalmology services. There is a group associated with another hospital providing services in Wolfeboro. They send patients a long distance to have procedures that could be completed at HH, enhancing access for the community.

The adult obesity rate in Carroll County is below the state and national average; however, the rate has increased over the past four years. Obesity is also a critical driver of comorbidities. Offering bariatric pre and post-operative services, along with non-surgical Bariatric options, would give HH patients increased access to services.

With regard to the Strategic Plan, both hospitals anticipate that the Rural Health Group, a subset of the Leadership Council outlined in the Combination Agreement, will provide information to the strategic planning process that will help rural hospitals identify their needs and plan for where services should be located for appropriate access for rural communities. The System CEO will be responsible for ensuring that matters raised by the Rural Hospital Group are communicated to the System Board. The Combination Agreement identifies efforts to deploy clinical specialists to rural communities, using human resources, and technological resources to shore up local access to acuity appropriate care. The agreement also identifies a more integrated delivery model that supports rural hospitals – specifically accessibility, quality and enhancement to reinforce the viability of the CAH hospitals in the System and reduce the need for patients being transferred to the larger institutions. While it is possible that some of the services noted above will not be a part of the System Strategic Plan, the exclusion of those services is highly unlikely given the alignment of the current needs of HH and MCH with their community needs and the current strategic priorities of the System. It is a priority of the System to support rural health care and access to services in rural areas. All of the services requested as commitments are services needed in the HH and MCH communities and would likely be supported in the System Strategic Plan.

37. Describe the nature of D-HH's presentations to MCH and HH as to its ability to support rural hospitals.

Representatives of Dartmouth-Hitchcock were invited by the Boards of MCH and HH to discuss the level of integration in the existing D-HH system and to provide examples of how D-HH has been able to better support the patients and communities of its member hospitals. There is a slide specific to potential support with the Proposed Combination. *See Attachment 14.*

The nature of the presentations included the rationale for D-HH desiring to pursue the proposed transaction, including the importance of helping to sustain the fragile rural health network in New Hampshire. D-HH has a proven track record of supporting rural hospitals through tele-health services, physician outreach services, educational offerings, and cost efficiencies gained through participation in the New England Alliance for Health. The presentations described the types of additional benefits that could only be supported through a clinically and financially integrated health system such as clinical service development, investment in integrated information systems, access to capital at lower cost, etc. MCH and HH were encouraged to reach out to current D-HH system members to hear directly from them about the benefits they derived by joining D-HH. The presentations also were aimed at hearing from MCH and HH about their needs and aspirations for their organizations.

38. Compare specific clinical and financial short to medium term goals established for GOH as of 2017 with the outcomes achieved as of 2019. Explain the reasons for the achievement or lack of achievement of those goals.

Attachments 15, 16, and 17 include a summary of the specific clinical and financial short to medium term goals established for GOH for the years 2017, 2018 and 2019. The actual summaries provided are snap shots in time but are reflective of the beginning of each year with the exception of 2019 which is represented by the sheet in effect today. These initiatives were formulated by an integration council comprised of leaders within CMC, MCH and HH and were then recommended to and adopted by the GOH Board. These summaries are the tracking sheets that were used as the primary means to track progress.

- Column 2 describes the initiative.
- Column 3 describes the expected deliverable or goal.
- Column 4 provides the expected timing of the deliverable.
- Columns 5 – 7 provides a color coded snap shot of whether the initiative was "on track", "at risk" or "behind" in terms of schedule, resources needed and budget.
- Column 8 describes at budgetary impact or investments required.
- Column 9 reflects a narrative of the key accomplishments.
- Column 10 lists the upcoming, next step deliverable(s).

Generally speaking, although the GOH affiliation is relatively new, its members and the patients they serve already are seeing progress towards a number of the intended goals of the transaction. Physician recruitment and staffing has improved, reducing staffing gaps; services have been expanded to increase access for patients of MCH and HH; capital investments have been made in information technology to improve quality of care; and the member hospitals have achieved cost savings. Under the affiliation agreement, though, MCH and HH each had the right to withdraw from GOH for two years, which has dissuaded investment and full integration. GOH's ability to realize many of the goals of the affiliation has been hampered by the system's lack of financial integration, limited capital, insufficient resources, and the short time GOH existed before it entered into serious discussions with D-HH.

Physician Recruitment and Retention:

The GOH affiliation has improved physician recruitment and staffing at member hospitals. Consistent with its affiliation goals, GOH has discussed a standardized red-carpet-provider interview process, credentialing system, and provider orientation and on-boarding, and has reduced and standardized the use of locums. Most significantly, GOH has utilized CMC-employed providers instead of locums to fill hospitalist staffing gaps at HH and MCH. GOH now has a full-time recruiter, the cost of whom is shared by the member hospitals, who has attracted a stable group of employed hospitalists to support all three hospitals. This has reduced the need for locums and thereby reduced costs, while at the same time increasing hospitalists' quality by replacing most out-of-state locum services with a more responsive and aligned partner. Moreover, where HH or MCH is unable to use a CMC-employed

physician to address hospitalist staffing gaps, through GOH, they can take advantage of a lower locum's rate than they would receive alone.

At the same time, the lack of a combined financial balance sheet has hampered the sharing of specialist physicians among GOH members because each member has an incentive to satisfy its own requirements first. For example, CMC has been able to provide only limited help to fill MCH's general surgery needs. To reduce its reliance on locums for general surgery, MCH requested that CMC share a general surgeon on a two-weeks-on, two-weeks-off basis. In light of its own general surgery needs, CMC was only able to provide general surgery coverage to MCH using CMC's employed surgeons for a few days a week for a limited period of time ending in April 2019. Once the financial statements are combined, the parties will have a greater incentive to share doctors across members to better meet the needs of the overall system. Facility and equipment fees are paid to the facility where care is provided. Without a combined balance sheet, any procedures completed by a CMC doctor at another facility that could be done at CMC or that requires the doctor to forgo a procedure at CMC results in lost facility and equipment revenues to CMC. But, under a combined balance sheet, those formerly lost revenues would stay within the system, promoting the sharing of doctors among members.

The Proposed Combination also will expand access to patient care through the sharing of physicians with MCH and other member facilities. For example, the travel time necessary to reach Peterborough from Manchester increases the difficulty of sharing physicians who may be on call at CMC in Manchester while also serving MCH in Peterborough. The Proposed Combination will allow greater sharing of physicians and call coverage due to the closer proximity of Keene and Peterborough.

Service Expansions

GOH also has achieved service expansions at MCH and HH. Most significantly, GOH rolled out "tele-stroke" services to MCH and HH. Using the same tele-stroke system as CMC, local providers at MCH and HH quickly can confer with neurologists to ensure that patients receive time-sensitive stroke treatments without losing critical time transporting the patient to the nearest neurologist. Each of the GOH hospital also has implemented tele-neurology services. In addition to ensuring that time-sensitive treatments are provided as soon as possible, these telehealth initiatives also reduce the need to transfer patients to distant high-acuity hospitals. GOH anticipates that the Proposed Combination with D-HH will enable even greater expansion of the tele-health programs and capabilities.

Capital Investments

In 2019, HH and CMC began to move onto a common Allscripts EMR system. Although the transfer is still underway, this change will make it possible for the hospitals to share clinical data, improving continuity of care when a patient moves between HH and CMC. The common EMR will make it easier for providers at each hospital to access the patient's records held at the other hospital. HH and CMC also have moved to the same ERP.

Although the transition to Allscripts offers the potential for real benefits, GOH's lack of financial integration has limited the success of the Allscripts implementation. Unlike financially integrated systems such as D-HH (and D-HH GO post-Combination), CMC does not have the financial incentive or the resources to assist smaller affiliated hospitals like MCH or HH in implementing a new EMR or ERP. Indeed, MCH has thus far chosen not to adopt an EMR or ERP system common to CMC and HH.

Cost Savings

In its short existence, GOH has achieved cost savings, but a lack of financial integration has limited opportunities to generate additional savings. One example of a cost-savings success is the post-affiliation refinancing of HH's debt, saving approximately $300,000 per year. Although the $300,000 in savings is not entirely attributable to the GOH affiliation, HH's association with CMC permitted HH to obtain both a lower interest rate and an additional $5 million line of credit, neither of which HH could have received on its own.

GOH's lack of financial integration has impeded other opportunities for cost savings. For example, GOH members also attempted, but failed, to obtain better rates on health insurance for their employees. The effort to obtain better rates fell apart because it would have required CMC to take on the additional risk associated with adding HH and MCH employees, and CMC has no incentive to take on such risk without a common bottom line.

Additional Benefits of the GOH Affiliation

The GOH affiliation also has produced other benefits and efficiencies, although such benefits may not be easily quantifiable, including:

- HH and MCH have benefited from access to CMC's in-house legal staff, including aligning members' compliance policies.
- Each member hospital has implemented the Cobblestone contract management system, which allowed MCH to replace an antiquated all-paper system.
- The addition of GOH-nominated board members has improved the quality and expertise of the MCH and HH boards.

39. Compare the current systems employed by CMC, MCH and HH for measurement of quality with those proposed following the transaction. Agreement Section 1.5, 5.3.6; Chartis Report pp. 50 – 51.

As noted in Appendix C of the Chartis Report (p.37), one of the first tasks after the Combination will be to inventory existing D-HH, CMC, MCH and HH quality measures and develop goals for D-HH GOH. Running parallel to that effort, D-HH GOH will be taking an inventory of the full suite of quality and value processes of D-HH, CMC, MCH and HH. Each of these inventory tasks is anticipated to take 1-3 months; the alignment of the processes is expected to take 1-3 years. Having previously integrated quality measurements and processes in five other affiliations with D-HH System members in a collaborative

fashion, D-HH has confidence that the same approach will be successful with CMC, HH, and MCH.

MCH and HH:

At both MCH and HH, quality is currently measured in a multitude of ways including data analysis, peer review, clinical outcome review, variance analysis, utilization review, and performance appraisals. Both use an Adverse Event Reporting Tool (Cactus-Symplar).

At MCH, data is also collected from committee/department reports, patient satisfaction and complaints, and other statistical reports. The outcome of any remedial action is documented through the various quality committees established at MCH. MCH has implemented a program known as "Just Culture", which balances the need for an open and honest reporting environment with the need for a quality learning environment and culture. MCH has also implemented a daily safety huddle (DASH); it also uses a variety of the Lean and Six Sigma tools, which are in use at D-HH. In 2019, MCH's efforts around quality and safety were recognized by the NH Hospital Association and Foundation for Health Communities by earning their Distinguished Honoring Excellence in Patient Safety and Quality Improvement Award.

At HH, each department and every employee is given the responsibility and authority to participate in the organization's quality improvement program. The hospital's culture and value of "continuous improvement" encourages employees to participate in successful quality programming such as the monthly Quality Improvement Meetings, the annual Quality Fair and Quality Assessment and Improvement Report. Huggins Hospital reports quality data, initiatives and progress through an organization-wide quality dashboard and as required to all regulatory agencies. A sample of the quality dashboard is set out on Attachment 18 (out of sequence) as the HH Quality Measure Dashboard. Quality is also reported through the hospital's Quality Care and Patient Experience Committee of the Board of Trustees. HH has a current 5-star rating in the latest CMS Hospital Compare results.

While both HH and MCH are smaller than CMC and D-HH, with fewer resources for data abstraction and reporting, the quality teams at both hospitals are well regarded. Both HH and MCH anticipate that a combination with D-HH will provide access to additional resources, a method of standardization for quality data reported across organizations, and guidance and support as they move towards achieving high reliability.

See Attachment 18 (out of sequence) (HH Quality Measure Dashboard).

CMC:

CMC is in the process of completing its response and will provide to the Unit in a supplemental submission.

D-HH:

D-H is a national leader in healthcare quality and has driven improved outcomes for patients at Dartmouth-Hitchcock Medical Center (caring for patients with complexity that is in the top 5% nationally) by implementing infrastructure and quality improvement processes to achieve quality and safety outcomes that are among the best in the nation (see Figure2).

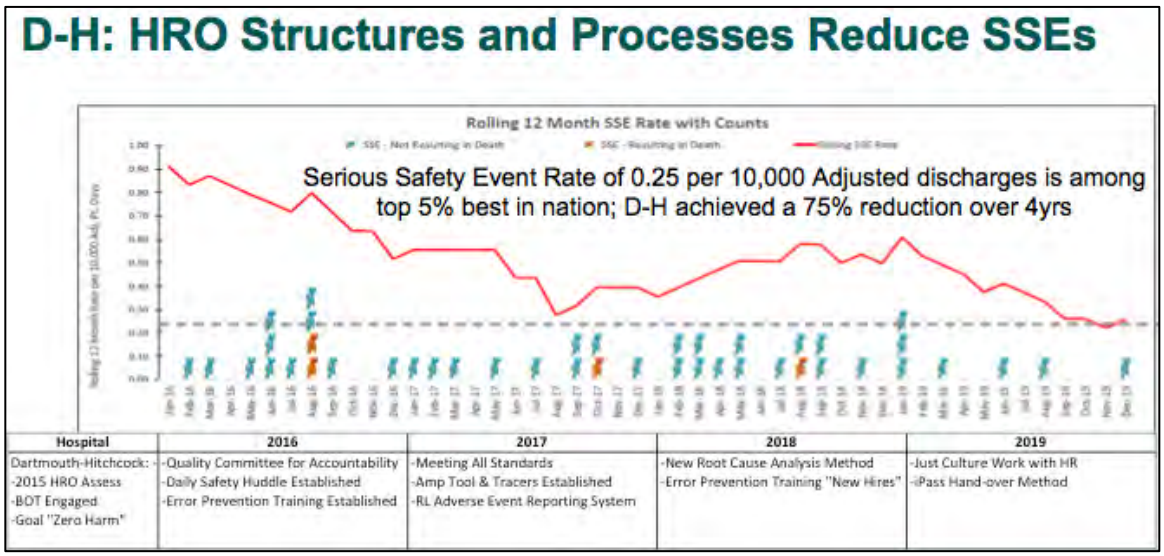


Figure 2: DHMC Serious Safety Event Rate Over 4yrs; Structures and processes implemented are shown in year implemented.

Safety is measured by counting patients who suffered complications that caused harm and were associated with a gap in care. DHMC trends the 12-month rolling average of these "Serious Safety Events" (i.e., SSEs) per 10,000 adjusted patient days to normalize for volume. DHMC's systematic implementation of a set of high reliability organizational best structures and processes has been associated with a 75% reduction in the SSE Rate over a 4-year period.

Most importantly, as DHMC affiliated with other hospitals through D-HH, it intentionally set out to implement the same structures and processes that deliver highly reliable performance and thus better outcomes. Similar to the DHMC experience, D-HH achieved a 50% reduction in SSEs over the initial 3yrs of implementation (see Figure 3).

(*intentional page break*)

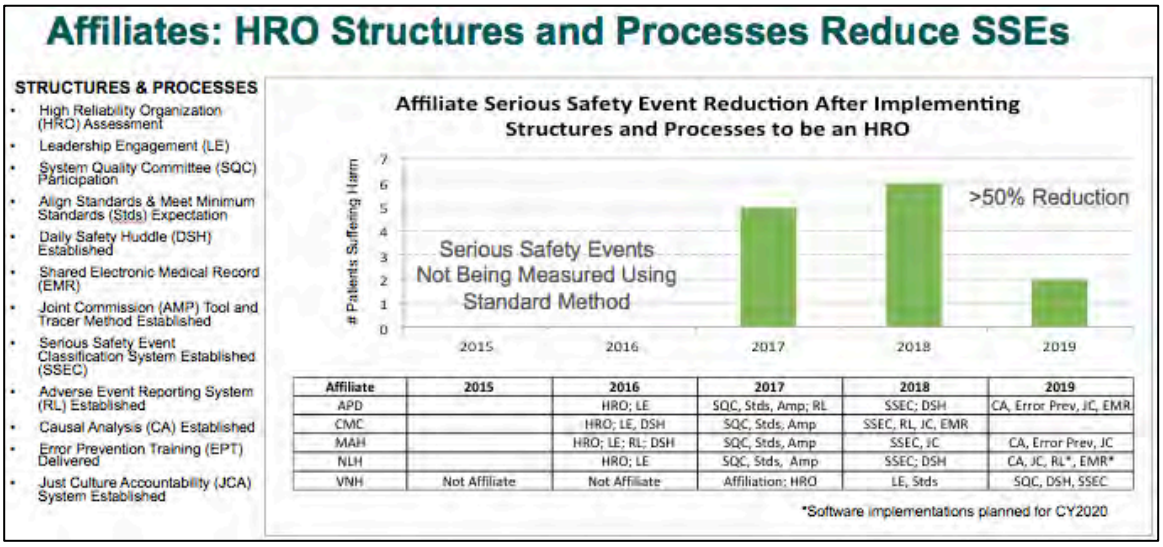


Figure 3: Implementation of High Reliability Organizational structures and processes has been associated with reduced Serious Safety Events

With the GraniteOne Health System, D-HH anticipates similar opportunities to enhance the current structures and processes for delivering the highest quality based on current capabilities. Having done this with five D-HH System members in a collaborative fashion, we have confidence the same approach would be applicable to CMC, HH and MCH.

40. Is it contemplated that a new regional president of Region I will be appointed within the first two years following the transaction date? Is it contemplated that a new president of CMC will be appointed within the first two years following the transaction date? Agreement Section 4.2.2(b).

The Parties have contemplated as set forth in the Combination Agreement that Dr. Joanne Conroy will serve as the President and CEO of D-HH GO, President and CEO of Mary Hitchcock Memorial Hospital and the President of Region I within the first two years following the transaction date.

Similarly, Dr. Joseph Pepe, who currently serves as the CEO of GOH and the President and CEO of CMC and the CMCHS system, would serve as the President of Region II and continue to serve as the President and CEO of CMC and the CMCHS System.

The Parties have recognized (e.g., by use of the word "initially" in Section 4.2.2(b)) that as they execute on the regional strategies to expand services and deliver on the commitments made in the Combination Agreement that it may become necessary over time for others to assist with leading initiatives, various strategies and day-to-day operations of various aspects of the system. The Parties also recognize the need to engage in prudent succession planning. To date, however, no such changes or plans have been determined. As set forth in Section 4.2.2(b), any appointment to the office of President of Region II, requires the approval of a majority of the GOH appointed members of the D-HH GO Board.

41. Describe the types and percentage of a patient's electronic medical records at CMC, MCH or HH will be available at a D-HH facility using interoperability tools, and vice versa. What is the timeline within which those tools can be implemented, and at what cost? What examples exist of successful short term use of interoperability tools within a combined hospital system? Agreement Section 5.4.1, Chartis Report, pp. 39-41.

The types of a patient's electronic medical record ("EMR") at CMC, MCH, or HH that will be available at a D-HH facility using interoperability tools, and vice versa, will be continuity of care documents ("CCDs") initially. CCDs are a summary of key clinical information necessary for providers to effectively continue a patient's care, such as problem lists, medications, allergies, and care plans. While CCDs are not intended to be a complete medical history for patients, and thus are not 100% of a patient's EMR, they are intended to include the most critical information about patients, and thus are a high percentage in terms of the significance of information in a patient's EMR versus the volume.

All EMRs, including those used at CMC, MCH, HH, and D-HH facilities produce CCDs for all patients. Currently, none of the EMRs push them between facilities even though they are technically capable of doing so. The timeline to optimize clinical workflows to standardize the CCDs to send and consume between facilities is approximately 12-18 months at an estimated cost of $250k using Commonwell, Carequality, and/or DB Motion exchange tools, which expedite connectively and maximize configurations. There is also the option to add launch functionality between D-HH's EMR and CMC's EMR, which will allow access to 100% of a patient's EMR between facilities when appropriate, in a short time frame of approximately 6 months at an estimated cost of $100-$200k.

A recent example of a successful short term use of interoperability tools within a combined hospital system stems from CMC's, MCH's, and HH's current GOH system. HH's current radiology group is departing, and so HH is transitioning to a group from D-HH to perform diagnostic reading services. Given HH's limited resources, CMC assisted HH to build a data integration interface from HH's current EMR to D-HH's current EMR and vice versa (D-HH built their portion). Specifically, the interface allows for the following exchange for all HH's patients who have any images services (which is a high percentage of all hospital patients):

- Patient data, including demographics, orders, allergies, etc., is sent electronically from HH's EMR to D-HH's EMR.
- D-HH electronically consumes the data directly into its EMR along with the picture archiving and communication system ("PACS") images from HH's system into D-HH's PACS.
- A D-HH radiologist then performs the diagnostic read within D-HH system, stores it for access within D-HH's EMR, and sends the results back to HH electronically.
- HH electronically consumes and stores the information, including results and PACS images within HH's EMR.

Notably, once HH goes live on the same EMR as CMC (which is in process), the results will be available to CMC as well. The cost for all of this data integration is very low and

estimated at only approximately $5k based on CMC and D-HH collectively spending about 100 hours of internal work. This type of data integration can be scaled and established for prescriptions, laboratory results, orders, clinical documentation, and more between the EMRs for D-HH and CMM/HH incrementally over a timeline of approximately 12-24 months, as desired by the facilities based on the implementation of a HIPAA privacy group structure for ease of sharing information for treatment, payment, and operations; clinical integration efforts; priority of business need; and return on investment analyses, among other factors. Estimated costs for this further interoperability work are $750k-$1M depending on actual scope and scale.

42. What is to be included in the Strategic Imperatives for Proposed Combination reserved to be included at Tab II of the Notice document?

The parties do not intend to include additional information for this tab at this time. In the process of coordinating the Joint Notice, the appendices labeling shifted and Tab II was labeled "Reserved" in an effort to not impact the labeling of the other appendices. Based on the Unit's question, it might have been more accurate to label the tab "Intentionally Omitted."

43. What constraints exist for D-HH to build its own inpatient facility in southern New Hampshire, as opposed to combining with an existing community hospital in that region?

In the process of conducting due diligence to determine the most efficient, effective means of achieving its strategic imperatives in southern New Hampshire, the D-HH Board of Trustees considered various options offered by senior management and expert consultants. Among those options was a "go it alone" approach by building a D-HH inpatient facility in the Greater Manchester area, which was ultimately rejected due to its prohibitive financial, programmatic, operational, labor, and political costs.

Analyses performed by Chartis sized a stand-alone D-HH facility in southern New Hampshire at approximately 100-150 beds, with most of the patient volume assumed to be drawn from other hospitals in the region. The patient volume assumptions, however, depend on D-HH's ability to alter the travel patterns and preferences of patients in southern New Hampshire hospitals, a significant unknown that creates risk for D-HH if it were to pursue a go it alone approach. Not only would this strategy have a destabilizing effect on local providers like CMC and SolutioNHealth but it also would invite greater market penetration by out-of-state health systems seeking to acquire one or more of those weakened local providers and drawing even more southern New Hampshire patients out-of-state for less convenient, more expensive specialty care. One of the purposes of the Proposed Combination is to offer specialty care closer to home and obviate the need for southern New Hampshire patients to seek such care at those more expensive, inconvenient out-of-state health systems.

The capital investment required to build 100-150 inpatient beds would be in the range of $150-$300 million, to say nothing of the length of time to market and the costs of operationalizing a full-service teaching hospital. These latter costs include hiring hundreds of clinical and administrative staff in a market already facing a critical shortage of health care workforce. High capital requirements to operationalize a new hospital would divert limited resources away from strategic priorities like behavioral health and rural health care, a hallmark of the Proposed Combination. Also, local hospitals would likely terminate or significantly limit professional service agreements and call coverage arrangements with D-H Clinic physicians, at a time when D-HH's capital requirements would be at their height.

Ultimately, the D-HH Board elected to pursue a combination with GraniteOne as the best alternative to these financial, operational and political constraints. Whereas a stand-alone D-HH inpatient facility would consist of approximately 100 - 150 beds at a cost of $150-$300 million, a combined D-HH GO inpatient facility would consist of nearly 400 beds at a joint cost of $200 million. Rather than undertaking the significant financial and operational risk involved with a standalone facility, D-HH believes that together, the Parties can use their combined resources to achieve the strategic objectives of the Proposed Combination. Thus, patients will realize the benefits of the Proposed Combination in a timelier, more cost-effective, less disruptive way than a "go it alone" strategy.

44. How many children in southern New Hampshire annually access specialized and emergency department neonatology or pediatric services at a) Massachusetts hospitals and b) Dartmouth-Hitchcock Medical Center?

a) Based on FY17 inpatient discharge data from Massachusetts (CHIA), there are more than 2,030 pediatric (ages 0-17) discharges across all specialties in Massachusetts hospitals originating from Hillsborough, Merrimack, and Rockingham counties. From this total, 720 were classified as emergent admissions.[7]
b) For the same period, Dartmouth-Hitchcock Medical Center saw 349 pediatric discharges, 245 of which were classified as emergent.[8]

45. Of the 1,900 southern New Hampshire patients who annually receive care for heart and vascular issues in Massachusetts, how many likely could still not be offered appropriate care at D-HHGO, even after implementation of the proposed initiatives?

As described in the analysis developed for the clinical integration strategy, roughly 1,900 southern New Hampshire heart and vascular patients leave the state for inpatient care. Some 700 of those patients will receive care in a Massachusetts hospital close to the New Hampshire border, and we conservatively estimated that those patients would likely not be retained in-state given travel patterns and market proximity. Of the remaining 1,200 out-migrating heart and vascular patients, it is estimated that over 130 patients would not be able

[7] Extracts from the Massachusetts CHIA data set must obscure record totals fewer than 11 discharges; for the totals reported in part a, this amounts to no more than 40 discharges.
[8] DHMC-reported inpatient records, FY2017

to receive care at CMC as they require heart transplants, other services which CMC does not currently perform and sends to Boston academic medical centers already, or services that CMC rarely performs (i.e., 10 or fewer operations per year) and often sends to Boston academic medical centers.

These estimates are based on an analysis of FY17 data from the Massachusetts Center for Health Information Analysis (CHIA), which has limited clinical detail on out-migrating patients.

GOVERNANCE

46. What mechanism will be in place following the 6-year transitional period to consider geographic, gender, ethnic, and religious diversity on the board of directors of the combined Dartmouth-Hitchcock Health GraniteOne (D-HHGO)? Agreement Schedule 3.3.3.

The parties are, and will continue to be, committed to best governance practices. Section 3.2.4 of the draft D-HHGO Bylaws requires nominees to the D-HHGO to possess skills and/or experience beneficial to D-HHGO in performing its corporate purposes as the manager of the D-HHGO System. The Nominating Committee of the D-HHGO Board likely will have a matrix of criteria for trustee nominations which will include the criteria set forth in Schedule 3.3.3 of the Combination Agreement, as well as other desired skills, experience and diversity of gender, ethnicity, geographic location, religious background, and other factors which will provide a diversity of perspectives and foster robust discussion at the D-HHGO Board meetings.

47. Explain what appears to be a conflict between the right of the D-HHGO board of directors to hire, evaluate and terminate the chief executive officer of MCH and HH, and the rights of the boards of directors of MCH and HH. Agreement Section 3.4.1(b)(ii); 3.4.5(c).

The D-HHGO Board of Trustees will retain the ultimate authority to hire, evaluate, compensate and terminate the chief executive officer of MCH and HH, as described in Section 3.4.1(b). This authority is repeated at the beginning of Section 3.4.5(c) to clarify that the right of the MCH and HH boards of trustees to give input on such decisions is not a limitation on the D-HHGO Board's authority over the MCH and HH chief executive officers. The D-HHGO Board does not intend to make such decisions lightly, however, and will seek input from the MCH and HH Boards who have the right to evaluate the performance of their chief executive officer and make advisory recommendations to the D-HHGO Board. Section 3.4.5(c) also provides a procedural requirement that the System Board Chair be made aware of any contrary recommendation of the applicable Member board of trustees before the System CEO is authorized to implement a decision regarding the MCH or HH chief executive officer. We do not see a conflict between these two provisions. We also note that

these provisions are consistent with prior D-HH System affiliations with its Member hospitals.

48. Explain how the reduction or closure of a clinical service at CMC, MCH or HH will be implemented by D-HHGO when the effect of that closure may harm the financial position of that hospital. Agreement Sections 3.4.l(b)(v) and 3.4.2(b)(v), 5.5.2(c), 5.3.3(a). State any clinical services being considered for closure after the transaction at CMC, MCH or HH. See, Agreement Section 2.8.

There are no clinical services being considered for reduction or closure if the Combination is approved and consummated. To the contrary, the parties have expressed their ongoing commitment to the continuation and expansion of health care services and the provision of rural healthcare. *See, e.g.*, Combination Agreement Recitals H and M, and Sections 1.3, 1.4, 1.7, 1.9, 2.2, 2.5 through 2.8, and 5.3.

The parties have learned through experience that quality improvements, cost reductions, innovative delivery methods, enhanced access to care and value-based reimbursement arrangements require clinical integration and coordinated planning throughout the System. The reserved power of D-HHGO to require changes in clinical services at Member hospitals is intended to further these purposes.

Section 5.3.3(a) of the Combination Agreement sets forth both DHHGO's commitment to rural healthcare and Core Services as defined in the Agreement. It then identifies various factors which must be considered in any proposed change to clinical services, including cost. The Combination Agreement expressly prohibits the termination of a Core Service solely because of its cost. Section 5.3.3(b) then describes the process to be followed for a change in clinical services. The essence of this process, however, is to improve the quality of, access to, and efficiency of health care services throughout the System and not to harm the financial position of a System Member.

As additional safeguards, Sections 3.4.1(b)(v) and 3.4.2(b)(v) of the Combination Agreement impose both qualifications and procedural requirements on the D-HHGO Board's exercise of the power to initiate clinical changes. Clinical changes are limited to the following purposes: (i) furtherance of System-wide strategies and objectives; (ii) furtherance of the clinical development and improvements described in Section 5.3 of the Combination Agreement; or (iii) to improve (not harm) the financial position of the System Member. In fulfillment of its limited fiduciary responsibilities, the D-HHGO Board then must consider the impact of the proposed change on the System Member's: (i) ability to meet the health needs of the communities it serves; (ii) ability of MCH and HH to retain critical access hospital status; (iii) quality and efficiency with which it can deliver health services; and (iv) charitable mission.

The D-HHGO Board also must weigh any proposed change in clinical services by the System Financial Principles described in Section 5.5.2(a). It would not require a change in clinical services if it caused a System Member to become unable to meet debt obligations or

materially impaired in its ability to continue to meet the health needs of the communities it serves.

The parties remain open to future, unforeseen changes in the delivery of healthcare which may require a reevaluation of, and adjustment to, the current model of health care services; however, the goal of the proposed combination is to enhance the quality and distribution of services provided to patients.

49. Explain whether the required reallocation of pre-transaction resources, including endowment funds and pre-transaction fund balance, from CMC, MCH or HH to D-HHGO may result in a detriment to that entity greater than its share of the benefit to be incurred by all of D-HHGO? Agreement 5.5.2(c).

The Combination Agreement does not require the reallocation of pre-transaction resources. The Agreement does make available for reallocation certain excess funds of a System Member but only for the purposes, and subject to the restrictions and processes, described in Section 5.5.2(c) of the Combination Agreement and discussed in the response to Question 18 above. Endowment funds, defined as donor-restricted assets, are never subject to reallocation and must remain held for their intended purposes. As noted previously, each System Member has determined that participation in the System is the most appropriate way to further its charitable mission and steward its charitable assets. Pre-transaction resources meeting the limitations described in Section 5.5.2(c) of the Combination Agreement can be used only for System-wide strategies and initiatives, which ultimately improve the viability of the System and thus benefit all of its Members.

50. Explain whether and how the D-HHGO board of directors may reduce or close a CMC clinical service important to its Catholic mission and identity, such as its Women's Wellness and Fertility Center and the Pregnancy Care Center. Agreement Section 3.4.2(a)(vii).

The D-HHGO Board of Trustees has no authority to reduce or close a CMC clinical service important to its Catholic mission and identity. Section 3.4.2(b)(v) of the Combination Agreement contains an express proviso that any clinical changes initiated by the D-HHGO Board at CMC or a CMCHS Subsidiary must be "consistent with Catholic moral teaching, the ERDs and Canon Law, CMC's values and do not result in the alienation of ecclesiastical goods." Any proposed clinical change at CMC or a CMCHS Subsidiary would require the prior approval of CMCHS if it determines that the change may impact the Catholic identity of, or adherence to Catholic moral teaching, the ERDs and Canon Law, by, CMC or a CMCHS Subsidiary. *See* Section 3.4.2(a)(vii) of the Combination Agreement.

51. Explain how MCH and HH were each free to consider joining other partners, apart from those negotiated collectively under GOH, as part of their due diligence for this

transaction. Describe the nature of their consideration of partners other than D-HH leading up to the pending transaction.

Both hospitals understood as they worked with GOH that there would be further development of the GOH system and that the system would need to become larger. Initially there was interest from Southern New Hampshire Medical Center ("SNHMC"), Frisbie Memorial Hospital ("Frisbie") and Exeter Hospital ("Exeter") as possible future partners. The market dynamics changed. SNHMC and Elliot formed SolutioNHealth. Exeter sought to be acquired by Massachusetts General Hospital ("MGH") and Frisbie faced such financial challenges that GOH did not have the capacity or ability to improve. The GOH board considered certain invitations to partner but ultimately there was a lack of an ability to assist those organizations.

CMC had been working with MGH in a clinical affiliation relationship and considered how GOH might work with MGH or D-HH for tertiary and quaternary referrals on a larger scale. The GOH Board meeting in the Spring of 2018, included discussion of possible partners for GOH. As members of the GOH Board, the HH and MCH CEOs and the other volunteer representatives of HH and MCH could have opposed any of the options presented. The GOH Board also discussed other New Hampshire hospitals that might be interested in joining GOH. Given the relatively small size of GOH, the limited financial integration of GOH and the developments described above, it made sense for GOH to be considering D-HH and MGH as potential partners, more so than bringing additional hospitals into GOH.

When MCH undertook its initial work to evaluate a partner in early 2014 and 2015, the RFP process included more than 30 organizations. MCH ultimately talked with 9 hospitals or systems in New Hampshire and in Massachusetts. MCH ultimately received and evaluated three final formal RFP responses from CMC, D-HH and Heywood Hospital in Massachusetts. Prior to joining GOH, HH also explored other options for affiliation, which included D-HH and seacoast area hospitals but elected to join GOH.

In October of 2018, HH and MCH were informed, through a presentation by Chartis to the GOH Board that CMC and D-HH were working toward an affiliation agreement. In December 2018, the Letter of Intent, as negotiated by CMC and D-HH, was presented to the HH and MCH Boards. It was presented for informational purposes only and was not voted on by either Board. In early 2019, HH and MCH negotiated an extension of the withdrawal provisions in the GOH Affiliation Agreement to allow either hospital to evaluate other potential partners if the D-HH GO system was determined not to be acceptable.

After the GOH board approved a non-binding letter of intent with D-HH to further the process of exploring the combination of the two systems, the Executive Committee of the MCH Board worked closely with its consultant from BKD, Wyatt Jenkins, to review the current environment nationally and to ask the question should MCH consider another option. The MCH Executive Committee determined that MCH had explored the other options and that little had changed since 2015 as it related to potential partners except for the changes in the local market dynamics and the formation of new relationships. Since MCH had previously interviewed and talked with D-HH in the former RFP evaluation process, the

MCH Board felt that D-HH was the best likely partner for GOH and ultimately for MCH. MCH has had a long standing relationship with D-HH as it has had with CMC.

Initially, MCH selected CMC as a partner in large part because the level of control through the reserve powers was less restrictive than what had been proposed by D-HH. However, much of what MCH hoped to accomplish as a system in GOH was hampered by the fact that GOH members did not share consolidated bottom lines which limited the work that could be done to construct the system. The MCH Board understood that the reserve powers needed to be more restrictive in order to work together in a more integrated fashion than had previously been possible with GOH.

Although the extension of the withdrawal rights allowed HH more time to consider options, the HH Board and leadership were concerned about having to exit GOH to not be a party to the affiliation contemplated by the Letter of Intent, and being back in the position of being independent. HH hired a consultant from Stroudwater to assist with evaluating HCA and MGH as potential partners as well as the option to be independent again. Stroudwater noted some potential benefits to HH relative to HCA and MGH; however, given the desire of the HH Board members and leadership to be affiliated with a New Hampshire system, it was ultimately decided to continue as part of GOH and to move forward with the combination with D-HH.

52. Explain the reason that D-HHGO requires the reserved power to remove any director of MCH or HH, given that D-HHGO must approve all such nominees. Agreement Section 3.4.1(b)(i).

The power of removal is a natural and necessary complement to the power of approval in connection with nominees to System Member governing boards. The Trustee Criteria set forth in Schedule 3.3.3 of the Combination Agreement are intended to be ongoing qualifications, and not just threshold criteria. If a trustee, contrary to expectations during the nomination process, behaves in a manner which is harmful to the System, then the System Board must have the power to remove that trustee if the Member Board fails to do so. This power is one which has been reserved to D-HH in previous affiliations with its Member hospitals.

53. What if any conflicts of interest or pecuniary benefit transactions have been disclosed by any of the directors of CMC, MCH. HH or [D-HH?] with respect to this transaction?

The parties identified only one pecuniary benefit transaction at the CMCHS Subsidiary level. Stephen Leblanc is a voting member of the Board of Directors of Alliance Health Services, one of the CMCHS Subsidiaries party to the Combination Agreement. Mr. Leblanc disclosed to the Board that as Chief Strategy officer, he is an officer of Dartmouth-Hitchcock Health and accordingly, the Alliance Health Services Board followed its conflict of interest policy and procedures with respect to the Board's approval of the proposed Combination and the Combination Agreement. The Board approval was done through unanimous written

consent. The resolutions recite the conflict and the process followed by the Board. While Mr. Leblanc signed the unanimous written consent resolutions as a Board member, his signature was qualified to indicate that he was refraining from voting on the proposed Combination and the Combination Agreement. *See Appendix IV(30).*

D-HHGO AND CATHOLIC IDENTITY

54. Explain the administrative steps that the Dartmouth-Hitchcock Clinics (D-HC) will take in proposed Region II "to ensure respect for the ERDs [Ethical and Religious Directives for Catholic Health Care Services of the United States Conference of Catholic Bishops (ERDs)] and CMC's Catholic identity and the avoidance of confusion among CMC patients who may be referred to a D-HC specialist." Agreement Section 4.2.2(e). How will the secular identity of DH-C be preserved under these circumstances? See Agreement Section 2.7.

The Catholic teachings and principles will continue to be recognized post combination. In any collaboration between a Catholic and non-Catholic healthcare partner, there may be a concern that the faithful community and the broader public might incorrectly believe that the Catholic entity is not different from the non-Catholic system and no longer follows and bears witness to the moral principles of Catholic healthcare. Some might incorrectly be led to think that the practices contrary to the ERDs performed at the non-Catholic entities are approved or condoned by CMC, or that CMC is now operating as "Catholic in name only." None of these potential concerns are valid in the proposed Combination. The Combination Agreement has provided mechanisms to ensure that patients are informed and not led to think that is the case.

As a bi-regionally managed system, D-HC in the southern part of the State, will be implementing administering a number of administrative steps to ensure that CMC continues to adhere to the Catholic moral teachings, the ERDs and Canon Law and that the faithful community is given clear opportunities to be informed in a way that ensure their medical care remains consistent with their beliefs. (Note: Most of these administrative steps are already voluntarily taken by D-HC specialists who provide services to CMC patients – see answer to question 59).

- D-HC will require ERD training among its providers practicing in Region II to ensure respect and understanding of the ERDs and CMC's Catholic Identity and the needs of Catholic patients who seek their care at CMC.

- D-HC will uphold CMC's existing Annual ERD Certification of D-HC Physicians Credentialed at CMC.

- D-HC will track and make available to CMC on an annual basis the number, nature and location of procedures that were performed at D-HC facilities that are inconsistent with the ERDs. As detailed above, those procedures and any potential future procedures that are inconsistent with the ERDs will be identified and D-HC will explicitly require and

confirm that these will be under the authority of the D-HC employed Medical Director(s) that manage D-HC services in Region II. With regard to reporting and oversight of the Medical Director(s), all matters pertaining to procedures that are inconsistent with Catholic moral teaching, the ERDs and Canon Law will be reported directly to the Chief Clinical Officer and Chief Operating Officer of D-HH GO.

- A "hotline" to the Office of Catholic Identity at CMC for reporting of alleged violations of the ERDs will be established and staffed to enable the faithful community to express concerns, ask questions and alert CMC of any matters that may need to be addressed.

- D-HC agrees to cooperate and participate in the CMC ERD Audit Process which includes an annual assessment and report to the Bishop on ERD compliance.

- D-HC is requiring that current D-HC employees continue the sole management and administration of any procedures that are inconsistent with Catholic moral teaching, the ERDs and Canon Law.

- There will be signage in some CMC and D-HC facilities to explain the applicability of the ERDs.

- CMC patients being referred to a D-HC OB/GYN specialist or other specialist will see the following disclosure on their consent forms:

> CMC is a member of Dartmouth-Hitchcock Health GraniteOne. While CMC and its providers and facilities are committed to following Catholic moral teaching and the ERDs, other members, providers and facilities in the system are not. You are being referred to a specialist or facility which is not Catholic and could be engaging in actions contrary to Catholic moral teaching and the ERDs. You are not being referred for any purpose contrary to Catholic moral teaching and the ERDs. Any procedures or educational materials they may offer that are not consistent with the ERDs are not approved by or within the scope of authority of CMC. If you have any questions about Catholic moral teaching and the ERDs or a procedure you are considering and whether it is consistent with these, then please contact the CMC Office of Catholic Identity at (603) 663-6440.

Ensuring respect for the Catholic Identity of CMC and its adherence to the moral Catholic teaching does not challenge the D-HC secular identity. These administrative steps do not equate to the implementation of the ERDs at the D-HC sites. These administrative steps are focused on ensuring informed consent, providing opportunities for education and disclosure, ensuring providers are informed and monitoring these activities. D-HH required Section 2.7 of the Combination Agreement which states the following:

> …D-HH is New Hampshire's only academic health system whose mission includes delivering innovative, high quality care across a broad range of services to patients and families regardless of where or how a patient chooses to utilize the health system….the provisions specific to CMC will neither be imposed upon nor mandatory for other System Members, who will not be precluded from providing services or conducting research and medical education activities prohibited by Catholic moral teaching, the ERDs or Canon Law….

It is worth noting that the proposed signage at D-HC makes this clear as well:

> Dartmouth-Hitchcock Health GraniteOne includes both Catholic and non-Catholic member hospitals. Only its Catholic members are committed to following Catholic moral teaching, including the ERDs. This is a non-Catholic provider and facility. Any procedures or educational materials that are not consistent with Catholic moral teaching and the ERDs are the sole responsibility of this provider or facility and its non-Catholic parent organizations. If you have questions about Catholic moral teaching and the ERDs or a procedure you are considering and whether it is consistent with these, then please contact the CMC Office of Catholic Identity at (603) 663-6440.

55. What if any restrictions will be in place for the management or supervision duties of Region II presidents who follow Joseph Pepe, MD with respect to Catholic moral teaching, the ERDs, or Canon Law? Must the president also serve as the president of CMC? Agreement Sections 2.6, 4.2.2(d) and (e), 11.3.5.

The provisions of Section 4.2.2(c)(i) are applicable when the President of Region II is also the President of CMC because the President of CMC is considered an administrator of a Catholic healthcare organization pursuant to the ERDs. If that were to change in the future, the D-HH employees responsible for procedures inconsistent with the ERDs could report to the President of Region II, however it is also possible that they would continue to report to the clinical officer of the System in Region I. The Parties have not mandated that the President of Region II always be the President of CMC.

(*intentional page break*)

56. Describe the level of particularity required in a proposed decision concerning a decision to be made by the board of directors of D-HHGO that would require a director who also serves as a director of CMC to object to that decision. Agreement Section 3.3.2(b). Would such a director be required to object to any decisions about the D-HHGO annual budget or about D-HHGO facilities that fund or house those objectionable procedures?

The initial Board appointments are made by D-HH and GOH, the secular co-member of CMC. It is not anticipated that there will be a significant amount of overlap of trustees on both the Board of D-HHGO and CMC, however, the Combination Agreement contemplates the possibility that an individual could be on both Boards. ERD n. 76 states that a Catholic member of a governing board of a non-Catholic health care organization board should make their opposition to immoral procedures known and not give their consent to any decisions approving procedures inconsistent with the ERDs. With respect to the D-HHGO Board, this will take the form of voting against immoral procedures. The level of particularity will be a statement in the minutes or consent resolution noting the reason for the no vote. If there is a vote at the Board level to approve a specific procedure that is inconsistent with the ERDs, Dr. Pepe, for example, being an ex-officio voting member of CMC and D-HHGO will vote no and state because the proposed procedure is contrary to the ERDs. Votes to approve a budget for example, which include the entire budget for a particular hospital that performs a procedure inconsistent with the ERDs, Dr. Pepe's vote would be "yes, with the exception of those line items pertaining to procedures [x] and [y] because those procedures are inconsistent with the ERDs." See the response to question 58 describing the individuals and the processes to assist Dr. Pepe in making those determinations.

57. Explain the significance of a public juridic person under Canon Law and why Catholic Medical Center Health System is the only such person among the CMC affiliates.

Public juridic person is an alternative sponsorship arrangement that allows Church entities to share resources and provide for Church oversight over those resources. Canon Law defines juridic persons as "aggregates of persons or of things ordered for a purpose which is in keeping with the mission of the church and which transcends the purpose of the individuals". Diocesan right means that public juridic person would be given juridical existence by the Bishop and would be answerable to the Bishop in its internal government. See CC 113-114, 116 and 120. Juridic persons are by their nature perpetual, but they can be suppressed or cease to exist. CC 120. A public juridic person is formed with statutes that define its purpose, governance, operations, conditions of membership, etc. Once written, the statutes are taken the appropriate ecclesiastical authority who approves them and forms the public juridic person.

A public juridic person is to canon law what a corporation is to civil law. It is an entity within the Roman Catholic Church that enables a ministry to relate directly to the church. For that reason, in the GraniteOne Affiliation Agreement, CMC Healthcare System ("CMCHS") was referred to as "the corporate arm of the Bishop" pertaining to CMC. In fact, CMCHS is formed under both Canon Law and Civil Law.

CMCHS is the public juridic person of diocesan right of CMC and other affiliated organizations. CMC Healthcare System was formed by Canon Law and Civil Law on June 22, 2011 by decree approving canonical statutes by the Most Reverend John B. McCormack, Bishop of Manchester.

A public juridic person like CMCHS can serve as such person for multiple entities which is the case with CMCHS.

58. What persons will CMCHS rely upon to make determinations that a proposed exercise by D-HHGO of its reserved powers or approval rights will affect the Catholic identity of CMC or will affect adherence to Catholic moral teaching, the ERDs and Canon Law?

The preamble of Part Six of the Ethical and Religious Directives for Catholic Health Care Services and Directive No. 67 make clear that the ultimate responsibility for interpreting and applying the ERDs rests with the diocesan bishop, thus it will be the Bishop that makes the final determination of whether a proposed exercise of D-HHGO of its reserved powers or approval rights will affect CMC's adherence to moral Catholic teaching, the ERDs and Canon Law. To make that determination, the Director of the Office of Catholic Identity, CMC's General Counsel, CMC President and CEO will provide information and advise the Bishop of the issues at hand and the Office of Catholic Identity will, if desired or necessary, seek an independent assessment by an ethicist like the National Catholic Bioethics Center to help inform the Bishop and assist with his decision. D-HH has agreed to cooperate with these reviews and will participate in providing necessary information and be a part of the information gathering to provide and inform the Bishop.

59. How has D-HH "acknowledged and supported CMC's Catholic identity and adherence to the ERDs" in its "long-standing clinical affiliations" with CMC? Agreement Recital L.

D-HH has acknowledged and supported CMC's Catholic Identity and adherence to the ERDs by its past and continued agreement to adhere to them while providing services at CMC's facilities, on CMC's campus and with CMC's patients. Dartmouth-Hitchcock has been in a certain professional services agreement with CMCHS subsidiary, Alliance Health Services since 2007. The agreement includes language mandating that their providers must comply with the ERDs. The AHS Professional Services Agreement has allowed Dartmouth-Hitchcock providers to successfully provide medical services for CMC's Mom's Place, Special Care Nursery, Intensive Care Unit, Women's Wellness and Fertility as well as other specialized services. All new Dartmouth-Hitchcock medical providers receive a copy of the current version of the *Ethical and Religious Directives for Catholic Health Care Services* and must sign the following Attestation of Understanding prior to serving at CMC:

"I, as a member of the Medical/Allied Health Staff, have received a copy of and will abide by the Ethical and Religious Directives for Catholic Health Care Services (ERDs) with respect to my practice at Catholic Medical Center. I realize that noncompliance with these directives violates the credentials policy and will result in disciplinary action up to and including the removal of my privileges."

D-HH presently participates and cooperates with CMC's ERDs audits as well as ethical consultation process. If D-HH providers have any questions whether services being provided are consistent with the ERDs, then they use the ethical consultation process, led by CMC's Director of Office of Catholic Identity to clarify. CMC also conducts "real-time" ERDs compliance audits to monitor ICD-X codes inputted by medical providers, including D-HH providers to determine whether services provided were contrary to the ERDs. CMC's Director of Office of Catholic Identity, Vice President of Medical Affairs and Executive Director of Community Health Services and Mission are notified immediately if a service contrary to the ERDs has been provided. Since the implementation of real time ERDs compliance audit, no D-HH providers have provided services at CMC contrary to the ERDs.

60. How comprehensive will be the CMCHS review of proposed decisions by D-HHGO that will affect CMC? For instance, will CMCHS conduct a review with an eye to the application of Catholic moral teaching beyond the ERDs to all proposed decisions by D-HHGO, such as decisions that may affect environmental or employment conditions or immigration status matters at CMC? What persons at CMCHS will conduct this review? Agreement Section 3.4.2.

The Bishop's Reserved Powers as defined in Section 3.4.2 of the Agreement (which includes approval by CMCHS) are there to ensure that CMC continues to adhere with the Catholic moral teaching, the ERDs and Canon Law. The Bishop's Reserved Powers require a direct approval or disapproval. CMCHS and the Bishop must be informed of proposed actions by D-HHGO and given an opportunity to assess whether there is a question or issue related to the moral Catholic teaching, the ERDs or the Canon Law. If there is a question or issue that that requires the Bishop's review, then the Bishop or CMCHS have the right to approve or disapprove of the action. These reviews will be led by the Director of Catholic Identity at CMC and applicable members of senior management or healthcare providers that are needed to help evaluate the moral question as well as members of the Diocese. If necessary, independent ethicists like the NCBC will be asked to help assess and advise on the issue to help inform CMCHS and the Bishop. These reviews will be as comprehensive as necessary to inform CMCHS and the Bishop so that they can determine whether the action is consistent or inconsistent with CMC's identity. While it is true that moral Catholic teaching and the Canon Law speak to a broader calling to promote the common good in areas outside of the health ministry, the ERDs focus on the ethical standards of behavior in health care that flow from the Church's teaching about the dignity of the human person and provide authoritative guidance on moral issues in health care. Limiting the application of Catholic moral teaching to healthcare consideration is also consistent with CMC's purposes set forth in its Articles of Agreement and CMC's mission is to carry out Christ's healing ministry by offering health, healing and hope to every individual who seeks its care. *See Appendix III(7).*

61. How will the benefits of risk-based reimbursement arrangements at D-HHGO be achieved if CMC might not participate in those arrangements due to a decision by CMCHS? Agreement Section 3.4.2(b)(iii)? Are there currently any available risk-based arrangements in which CMC has refused to participate due to violation of the ERDs?

The Parties' anticipate that CMC may participate in risk-based reimbursement arrangements. In the Parties' collective experience there has not been a risk-based arrangement that they have participated in that had an issue with the ERDs. There is not any risk-based arrangement that CMC has refused to participate in due to a violation of the ERDs.

62. What would be the basis for CMCHS to refuse to permit CMC to participate in a risk-based arrangement?

The risk-based arrangement would have to be contrary to the ERDs, however, based on CMC's experience, there has not been a risk-based arrangement that had an ERD question prohibiting participation.

63. Identify other transactions in the United States by which a secular academic medical center became the sole or co-member of a Catholic hospital as part of a health system. Of those transactions, which most closely resemble the proposed transaction?

There are a number of examples of secular academic medical centers partnering with Catholic hospitals in the same healthcare delivery system. CMC is in the process of completing its response and will provide to the Unit in a supplemental submission.

64. How will the prohibition on certain referrals by D-HHGO providers contracted by CMC apply in the case of a patient who requests a referral, and which patient the provider considers unable to understand fully the potential consequence of the provider's observance of that prohibition? May the provider make a referral to a provider for that service outside of D-HHGO? Agreement Section 4.1.3, 4.2.2(e)(vii).

Section 4.1.3 of the Combination Agreement makes clear that all medical providers of services at CMC cannot make referrals for procedures contrary to Catholic moral teaching and the ERDs:

> "Consistent with the provisions of Section 2.6 above, no provider employed or contracted by CMC or by any of the CMCHS Subsidiaries and acting in the course of the provider's duties to CMC or a CMCHS Subsidiary, as may be applicable, and its patients may be required or permitted to make referrals to any Member of the System for procedures that are inconsistent with Catholic moral teaching, the ERDs or Canon Law."

To ensure that patients receiving services at D-HC are aware that only Catholic hospitals and providers are responsible for following the ERDs, Section 4.2.2 (e)(viii) of the Combination Agreement states that "D-HC also will display the following disclosure in those Region II waiting rooms and exam rooms that are utilized in a manner not consistent with the ERDs:

> Dartmouth-Hitchcock Health GraniteOne includes both Catholic and non-Catholic member hospitals. Only its Catholic members are committed to following Catholic moral teaching, including the ERDs. This is a non-Catholic provider and facility. Any procedures or educational materials that are not consistent with Catholic moral teaching and the ERDs are the sole responsibility of this provider or facility and its non-Catholic parent organizations. If you have questions about Catholic moral teaching and the ERDs or a procedure you are considering and whether it is consistent with these, then please contact the CMC Office of Catholic Identity at (603) 663-6440."

DH-C medical providers who provide services at CMC are and will continue to be educated that they are unable to directly refer CMC patients to D-HC or other health care institutions for medical services contrary to the ERDs. If a patient requests a transfer to another facility to receive services elsewhere, both D-HC and CMC will honor the transfer of care.

In the case described in the question, it is incumbent on the providers to provide all reasonable information about the essential nature of the proposed treatment and its benefits, its risks, side-effects, consequences and cost, and any reasonable and morally legitimate alternatives. The introduction statement of Part One of the ERDs make clear: "within a pluralistic society, Catholic health care services will encounter requests for medical procedures contrary to the moral teaching of the Church. Catholic health care does not offend the rights of individual's conscience by refusing to provide or permit medical procedures that are judged morally wrong by the teaching authority of the Church." The patient is an independent moral agent free to decide where and from whom he or she will seek care. The provider or institution may offer to assist the patient with a transfer of care to another provider or institution of the patient's choosing, without stating where the patient might go to receive the non-ERD procedure. A general list of other providers or institutions based on geographic vicinity or even area of specialty will be provided.

65. What CMC specific facilities and CMCHS subsidiary practices are subject to the ERDs?

All CMC facilities and employed providers follow the ERDs, including joint ventures. Typically, there is language similar to the following in joint venture agreements, including those owned or affiliated by CMCHS subsidiary practices (example provided is from the Alliance Urgent Care Services, LLC which is the urgent care partnership with ClearChoiceMD):

AAS, as an Affiliate of a Catholic healthcare system, operates in a manner consistent with the Ethical and Religious Directives for Catholic Health Care Services, as promulgated by the United States Conference of Catholic Bishops as amended from time to time, and as interpreted by the Roman Catholic Bishop of the Diocese of Manchester (the "**ERDs**"). Accordingly, the services to be furnished by the Company in the Urgent Care Clinic shall be performed in a manner that is consistent with the ERDs.

The specific facilities and CMCHS subsidiary practices that are subject to the ERDs are as follows:

Acute Care Hospital Campus:

Catholic Medical Center (Manchester)

CMC Employed Hospital Specialty Care Services:

New England Heart and Vascular Center (Manchester - State-wide)
Women's Wellness & Fertility Center (Manchester)
Mom's Place and Special Care Nursery (Manchester)
Breast Care Center (Bedford)
New England Weight Management Institute (Manchester – State-wide)
Surgical Services
Rehabilitation Services
Respiratory
Sleep Care

Dartmouth-Hitchcock Services at the CMC Campus:

Dartmouth-Hitchcock Norris Cotton Cancer Center (Manchester)

Alliance Health Services:

Endocrinology (Manchester)
Obstetrics & Gynecology (Manchester)
Internal Medicine (Manchester/Bedford)
Pediatrics (Manchester/Bedford)
Primary Care/Family Medicine (Manchester/Bedford)
Pulmonary (Manchester)
Rheumatology (Manchester)
Surgical Services (Manchester)

Independent Provider Services Subject to the ERDs on the CMC Campus or at CMC Facilities:

US Acute Care Solutions (Emergency Department – Manchester)

Manchester Urology Associates, PA (Manchester)
New Hampshire Neurospine Institute (Manchester)
New Hampshire Orthopedics (Bedford/Manchester)
Matrix Pathology and Laboratory Services, PLLC (Manchester)
Southern New Hampshire Radiology Consultants (Manchester)
Telespecialists (Manchester)

Ambulatory Centers:

Bedford Ambulatory Surgery Center (Bedford)

Office Based Procedures:

CMC Vein & Vascular Center (Bedford)

Urgent Care:

CMC Urgent Care (Bedford)
ClearChoice CMC (Goffstown)
ClearChoice CMC (Hooksett)

Primary Care Practices:

Amoskeag Family Practice (Manchester)
Bedford Center Internal Medicine & Pediatrics (Bedford)
Family Physicians of Manchester (Manchester)
Goffstown Family Practice (Goffstown)
Granite State Internal Medicine (Bedford)
Highlander Way Internal Medicine (Manchester)
Hooksett Internal Medicine (Hooksett)
Lakeview Internal Medicine (Hooksett)
Queen City Medical Associates (Manchester)
Webster Street Internal Medicine (Manchester)
Willowbend Family Practice (Bedford)

Amoskeag Health Westside Neighborhood Health Center

Sleep Care:
CMC Sleep Center (Manchester)

Other CMCHS Subsidiaries for which the ERDs Apply:

Granite Health Asset Holding Company, LLC (Applicable to CMC's interest in the Tufts Health Freedom Plan)
NH Value Care, LLC (Accountable Care Organization)

Alliance Ambulatory Services (Holding company for CMC interests in the Bedford Ambulatory Surgery Center, LLC and Alliance Urgent Care Services, LLC)
Alliance Enterprises (real estate holding company - Manchester)
Alliance Resources (real estate holding company - Manchester)
Alliance Health Services (partnership with Dartmouth-Hitchcock Health – Bedford/Manchester)
CMC Physician Practice Associates (employs providers)

These facilities are routinely audited by the Director of the Office of Catholic Identity to ensure proper signage if applicable and to ensure literature and educational materials are consistent with the moral Catholic teaching.

66. What is the purpose of requiring D-HC to report annually to CMC the number, nature and location of procedures in Region II that are inconsistent with the ERDs? Agreement Section 4.2.2(e)(iii).

It is important that the Bishop be informed of the medical procedures contrary to the ERDs so that he can ensure the appropriate oversight of CMC and he can address and counsel the faithful. It is also a means to ensure and support that such procedures are not occurring at CMC. In fact, the ERDs require that an organization collaborating with a non-Catholic entity periodically review whether the agreement is being effectively implemented in accord with moral principles: "The Catholic party in a collaborative arrangement has the responsibility to assess periodically whether the binding agreement is being observed and implemented in a way that is consistent with the natural moral law, Catholic teaching, and canon law." Directive No. 72.

67. If D-HHGO reevaluates or eliminates the proposed bi-regional structure, will the requirements of Agreement Section 4.2.2(e) apply to all D-HC operations? Agreement Section 4.2.2(a).

Yes, these stipulations will always exist due to the level of financial, clinical and operational integration sought and so long as CMC is a part of the system.

68. Have the parties determined whether the D-HH Pooled Investment Program is consistent with the Socially Responsible Investment Guidelines of the United States Conference of Catholic Bishops? If not consistent, can CMC's endowment participate in some, but not all, of the Pooled Investment Program? Agreement Section 5.5.1.

The parties have not determined whether the D-HH Pooled Investment Program is consistent with the Socially Responsible Investment Guidelines of the United States Conference of Catholic Bishops. To that end, the parties have not determined whether CMC would participate in the Pooled Investment Program. The Socially Responsible Investment Guidelines are not that different from other social conscious investments – they call Catholic institutions to exercise faithful, competent and socially responsible stewardship in how it manages its financial resources.

The foregoing responses are submitted by the undersigned on behalf of the respective organizations, and to their knowledge are true and complete.

GRANITEONE HEALTH AND ITS MEMBERS

By: *s/ Jason E. Cole*
Name: Jason E. Cole
Title: Vice President & General Counsel, duly-authorized

DARTMOUTH-HITCHCOCK HEALTH

By: *s/ John P. Kacavas*
Name: John P. Kacavas
Title: Chief Legal Officer & General Counsel, duly-authorized.

INDEX OF ATTACHMENTS:

NO.	DESCRIPTION
1.	CMC Summary of Value and Risk-based Revenue
2.	HH Summary of Risk-Based Revenue
3.	GraniteOne, CMCHS, MCH and HH Financial Results for Quarter Ended 12/31/19
4.	D-HH Financial Results for Quarter Ended 12/31/19
5.	CMCHS Audited Financial Statements FY 2019
6.	CMC Audited Financial Statements FY 2019
7.	MCH Audited Financial Statements FY 2019
8.	HH Audited Financial Statements FY 2019
9.	MCH and HH Management Letters
10.	CMCHS Best Practices Letter
11.	CMCHS No Material Weakness Letter
12.	D-H Endowment Fund Policy
13.	A - NHAG Donor Restricted Funds MCH / B – NHAG Donor Restricted Funds HH
14.	Expected Benefits of Combination 4-19-19 MCH
15.	GraniteOne Integration Priorities Summary – 2017
16.	GraniteOne Integration Priorities Summary – 2018
17.	GraniteOne Integration Priorities Summary – 2019
18.	HH Quality Dashboard

Attachment 1

CMC Summary of Value and Risk-based Revenue

Table of Patient Service Revenue Derived from Value or Risk-based Arrangements
(Confidential/Exempt from Public Disclosure pursuant to RSA 91-AL5, IV (financial information)

Attachment 2

HH Quality Payments for FY 2015-2019

Table of Patient Service Revenue Derived from Value or Risk-based Arrangements
(Confidential/Exempt from Public Disclosure pursuant to RSA 91-AL5, IV (financial information)

Attachment 3

GraniteOne, CMCHS, MCH and HH Financial Results for Quarter Ended 12/31/19

GraniteOne HEALTH

GraniteOne Health
Combined Financial Results

December 31, 2019

CMC CATHOLIC MEDICAL CENTER

Huggins Hospital

Monadnock COMMUNITY HOSPITAL

GraniteOne Health
Consolidated Financial Results
December 31, 2019

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GraniteOne Health
Combined Statement of Operations
Year to Date Period Ended December 31, 2019

*excludes top-side entries	YEAR TO DATE ACTUAL 12/31/2019	BUDGET 12/31/2019	VARIANCE	PERCENT
NET PATIENT SERVICES REVENUES	155,284,194	159,180,472	(3,896,278)	-2.4%
Other Operating Revenues	7,131,631	7,934,391	(802,760)	-10.1%
NET OPERATING REVENUES	162,415,825	167,114,863	(4,699,038)	-2.8%
OPERATING EXPENSES				
Salaries	76,866,886	77,256,348	(389,462)	-0.5%
Benefits	17,927,569	17,795,640	131,929	0.7%
Physician Fees	4,156,069	4,232,513	(76,444)	-1.8%
Supplies	31,659,136	32,433,444	(774,308)	-2.4%
Other	20,990,520	21,357,027	(366,507)	-1.7%
Medicaid Enhancement Tax	7,159,168	7,230,257	(71,089)	-1.0%
Depreciation	6,595,561	6,947,991	(352,429)	-5.1%
Interest	1,588,038	1,690,484	(102,447)	-6.1%
TOTAL OPERATING EXPENSES	166,942,947	168,943,703	(2,000,756)	-1.2%
GAIN/(LOSS) FROM OPERATIONS	**(4,527,122)**	**(1,828,840)**	**(2,698,282)**	**147.5%**
Net Margin	-2.8%	-1.1%	-1.7%	154.7%
TOTAL NON OPERATING REVENUES/EXPENSES	2,861,745	(145,170)	3,006,915	-2071.3%
GAIN AFTER NON OPERATING REVENUES	**$ (1,665,376)**	**$ (1,974,010)**	**$ 308,633**	**-15.6%**

Stats:		
Salary and Benefits as a % of NPSR (xDSH)	63.8%	62.4%
Benefits as a % of Salaries	23.3%	23.0%
Operating Margin %	-2.8%	-1.1%
EBITDA %	2.3%	4.1%

GraniteOne Health
Combining Statement of Operations including Topside Entries
Year to Date Period Ended December 31, 2019

	Granite One	CMC Healthcare System	Huggins Hospital	Monadnock Community Hospital	Eliminations	Topside Entries	Total System
NET PATIENT SERVICES REVENUES	**-**	**118,296,071**	**15,427,461**	**21,560,662**	**-**	**-**	**155,284,194**
Other Operating Revenues	143,643	5,192,263	1,400,124	1,428,786	(1,033,184)	-	7,131,631
NET OPERATING REVENUES	**143,643**	**123,488,334**	**16,827,585**	**22,989,449**	**(1,033,184)**	**-**	**162,415,825**
OPERATING EXPENSES							
Salaries	105,350	59,581,099	8,185,910	9,011,562	(17,036)	-	76,866,886
Benefits	4,976	13,623,681	1,732,120	2,566,793	-	-	17,927,569
Physician Fees	-	2,152,159	879,946	1,597,422	(473,458)	-	4,156,069
Supplies	-	25,837,586	1,694,943	4,126,607	-	-	31,659,136
Other	-	15,649,035	2,658,747	3,225,429	(542,690)	-	20,990,520
Medicaid Enhancement Tax	-	5,513,526	623,539	1,022,103	-	-	7,159,168
Depreciation	-	4,264,412	1,233,431	1,097,718	-	310,533	6,906,094
Interest	-	1,090,944	246,084	251,010	-	-	1,588,038
TOTAL OPERATING EXPENSES	**110,326**	**127,712,443**	**17,254,720**	**22,898,643**	**(1,033,184)**	**310,533**	**167,253,480**
GAIN/(LOSS) FROM OPERATIONS	**33,317**	**(4,224,109)**	**(427,135)**	**90,805**	**-**	**(310,533)**	**(4,837,654)**
Net Margin	***23.2%***	***-3.4%***	***-2.5%***	***0.4%***	***0.0%***	***100.0%***	***-3.0%***
TOTAL NON OPERATING REVENUES/EXPENSES	-	470,441	1,948,908	442,396	-	-	2,861,745
GAIN AFTER NON OPERATING REVENUES	**$ 33,317**	**$ (3,753,668)**	**$ 1,521,773**	**$ 533,201**	**$ -**	**$ (310,533)**	**$ (1,975,909)**

GraniteOne Health
Combined Statement of Operations
Quarter Ended December 31, 2019

*excludes top-side entries	Quarter Ended December 31, 2019 ACTUAL 12/31/2019	BUDGET 12/31/2019	VARIANCE	PERCENT
NET PATIENT SERVICES REVENUES	155,284,194	159,180,472	(3,896,278)	-2.4%
Other Operating Revenues	7,131,632	7,934,391	(802,760)	-10.1%
NET OPERATING REVENUES	162,415,826	167,114,863	(4,699,038)	-2.8%
OPERATING EXPENSES				
Salaries	76,866,886	77,256,348	(389,462)	-0.5%
Benefits	17,927,569	17,795,640	131,929	0.7%
Physician Fees	4,156,069	4,232,513	(76,444)	-1.8%
Supplies	31,659,136	32,433,444	(774,308)	-2.4%
Other	20,990,520	21,357,027	(366,506)	-1.7%
Medicaid Enhancement Tax	7,159,168	7,230,257	(71,089)	-1.0%
Depreciation	6,595,561	6,947,991	(352,429)	-5.1%
Interest	1,588,038	1,690,484	(102,447)	-6.1%
TOTAL OPERATING EXPENSES	166,942,947	168,943,703	(2,000,756)	-1.2%
GAIN/(LOSS) FROM OPERATIONS	**(4,527,121)**	**(1,828,840)**	**(2,698,282)**	**147.5%**
Net Margin	-2.8%	-1.1%	-1.7%	154.7%
TOTAL NON OPERATING REVENUES/EXPENSES	2,861,745	(145,170)	3,006,915	-2071.3%
GAIN AFTER NON OPERATING REVENUES	**$ (1,665,376)**	**$ (1,974,009)**	**$ 308,633**	**-15.6%**

Stats:		
Salary and Benefits as a % of NPSR (xDSH)	63.8%	62.4%
Benefits as a % of Salaries	23.3%	23.0%
Operating Margin %	-2.8%	-1.1%
EBITDA %	2.3%	4.1%

GraniteOne Health
Combining Statement of Operations including Topside Entries
Quarter Ended December 31, 2019

	Granite One	CMC Healthcare System	Huggins Hospital	Monadnock Community Hospital	Eliminations	Topside Entries	Total System
NET PATIENT SERVICES REVENUES	**-**	**118,296,071**	**15,427,461**	**21,560,662**	**-**	**-**	**155,284,194**
Other Operating Revenues	143,643	5,192,263	1,400,124	1,428,786	(1,033,184)	-	7,131,632
NET OPERATING REVENUES	**143,643**	**123,488,334**	**16,827,585**	**22,989,449**	**(1,033,184)**	**-**	**162,415,826**
OPERATING EXPENSES							
Salaries	105,350	59,581,099	8,185,910	9,011,562	(17,036)	-	76,866,886
Benefits	4,976	13,623,681	1,732,120	2,566,793	-	-	17,927,569
Physician Fees	-	2,152,159	879,946	1,597,422	(473,458)	-	4,156,069
Supplies	-	25,837,586	1,694,943	4,126,607	-	-	31,659,136
Other	-	15,649,035	2,658,747	3,225,429	(542,690)	-	20,990,520
Medicaid Enhancement Tax	-	5,513,526	623,539	1,022,103	-	-	7,159,168
Depreciation	-	4,264,412	1,233,431	1,097,718	-	310,533	6,906,094
Interest	-	1,090,944	246,084	251,010	-	-	1,588,038
TOTAL OPERATING EXPENSES	**110,326**	**127,712,443**	**17,254,720**	**22,898,643**	**(1,033,184)**	**310,533**	**167,253,480**
GAIN/(LOSS) FROM OPERATIONS	**33,317**	**(4,224,109)**	**(427,135)**	**90,805**	**-**	**(310,533)**	**(4,837,654)**
Net Margin	***23.2%***	***-3.4%***	***-2.5%***	***0.4%***	***0.0%***	***100.0%***	***-3.0%***
TOTAL NON OPERATING REVENUES/EXPENSES	-	470,441	1,948,908	442,396	-	-	- 2,861,745
GAIN AFTER NON OPERATING REVENUES	**$ 33,317**	**$ (3,753,667)**	**$ 1,521,773**	**$ 533,201**	**$ -**	**$ (310,533)**	**$ (1,975,909)**

CMC Healthcare System
Statement of Operations
Quarter Ended December 31, 2019

	Quarter Ended December 31, 2019						
	ACTUAL 12/31/2019	BUDGET 12/31/2019	VARIANCE	PERCENT	YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	PRIOR YEAR to DATE
NET PATIENT SERVICES REVENUES	118,296,071	122,116,812	(3,820,741)	-3.1%	118,296,071	122,116,812	117,886,750
Other Operating Revenues	5,192,263	6,004,938	(812,675)	-13.5%	5,192,263	6,004,938	7,626,756
NET OPERATING REVENUES	123,488,334	128,121,751	(4,633,416)	-3.6%	123,488,334	128,121,751	125,513,506
OPERATING EXPENSES							
Salaries	59,581,099	59,984,570	(403,471)	-0.7%	59,581,099	59,984,570	58,685,054
Benefits	13,623,681	13,009,079	614,602	4.7%	13,623,681	13,009,079	12,311,832
Physician Fees	2,152,159	2,222,431	(70,272)	-3.2%	2,152,159	2,222,431	1,586,399
Supplies	25,837,586	26,969,745	(1,132,159)	-4.2%	25,837,586	26,969,745	26,085,133
Other	15,649,035	15,723,340	(74,306)	-0.5%	15,649,035	15,723,340	14,824,123
Medicaid Enhancement Tax	5,513,526	5,574,096	(60,570)	-1.1%	5,513,526	5,574,096	5,170,440
Depreciation	4,264,412	4,494,093	(229,680)	-5.1%	4,264,412	4,494,093	4,464,602
Interest	1,090,944	1,116,606	(25,662)	-2.3%	1,090,944	1,116,606	1,098,203
TOTAL OPERATING EXPENSES	127,712,443	129,093,960	(1,381,518)	-1.1%	127,712,443	129,093,960	124,225,785
GAIN/(LOSS) FROM OPERATIONS	**(4,224,109)**	**(972,210)**	**(3,251,899)**	**334.5%**	**(4,224,109)**	**(972,210)**	**1,287,721**
Net Margin	-3.4%	-0.8%	-2.7%	350.8%	-3.4%	-0.8%	1.0%
TOTAL NON OPERATING REVENUES/EXPENSES	470,441	(321,746)	792,187	-246.2%	470,441	(321,746)	1,429,848
GAIN AFTER NON OPERATING REVENUES	**$ (3,753,667)**	**$ (1,293,956)**	**$ (2,459,712)**	**190.1%**	**$ (3,753,668)**	**$ (1,293,956)**	**$ 2,717,569**
Stats:							
Salary and Benefits as a % of NPSR (xDSH)	64.7%	62.4%			64.7%	62.4%	
Benefits as a % of Salaries	22.9%	21.7%			22.9%	21.7%	
Operating Margin %	-3.4%	-0.8%			-3.4%	-0.8%	
EBITDA %	0.9%	3.6%			0.9%	3.6%	

Huggins Hospital
Statement of Operations
Quarter Ended December 31, 2019

	Quarter Ended December 31, 2019						
	ACTUAL 12/31/2019	BUDGET 12/31/2019	VARIANCE	PERCENT	YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	PRIOR YEAR to DATE
NET PATIENT SERVICES REVENUES	15,427,461	14,793,560	633,901	4.3%	15,427,461	14,793,560	13,846,427
Other Operating Revenues	1,400,124	1,176,567	223,556	19.0%	1,400,124	1,176,567	1,571,051
NET OPERATING REVENUES	16,827,585	15,970,127	857,458	5.4%	16,827,585	15,970,127	15,417,478
OPERATING EXPENSES							
Salaries	8,185,910	7,897,712	288,198	3.6%	8,185,910	7,897,712	7,493,739
Benefits	1,732,120	1,669,001	63,119	3.8%	1,732,120	1,669,001	1,625,821
Physician Fees	879,946	863,414	16,532	1.9%	879,946	863,414	758,610
Supplies	1,694,943	1,398,223	296,720	21.2%	1,694,943	1,398,223	1,302,917
Other	2,658,747	2,828,922	(170,176)	-6.0%	2,658,747	2,828,922	2,585,682
Medicaid Enhancement Tax	623,539	623,539	(0)	0.0%	623,539	623,539	613,298
Depreciation	1,233,431	1,312,500	(79,069)	-6.0%	1,233,431	1,312,500	1,147,937
Interest	246,084	314,376	(68,293)	-21.7%	246,084	314,376	286,480
TOTAL OPERATING EXPENSES	17,254,720	16,907,688	347,032	2.1%	17,254,720	16,907,688	15,814,483
GAIN/(LOSS) FROM OPERATIONS	**(427,135)**	**(937,561)**	**510,426**	**-54.4%**	**(427,135)**	**(937,561)**	**(397,005)**
Net Margin	-2.5%	-5.9%	3.3%	-56.8%	-2.5%	-5.9%	-2.6%
TOTAL NON OPERATING REVENUES/EXPENSES	1,948,908	67,500	1,881,408	2787.3%	1,948,908	67,500	1,373,856
GAIN AFTER NON OPERATING REVENUES	**$ 1,521,773**	**$ (870,061)**	**$ 2,391,834**	**-274.9%**	**$ 1,521,773**	**$ (870,061)**	**$ 976,851**
Stats:							
Salary and Benefits as a % of NPSR (xDSH)	66.7%	68.1%			66.7%	68.1%	
Benefits as a % of Salaries	21.2%	21.1%			21.2%	21.1%	
Operating Margin %	-2.5%	-5.9%			-2.5%	-5.9%	
EBITDA %	6.3%	4.3%			6.3%	4.3%	

Monadnock Community Hospital
Statement of Operations
Quarter Ended December 31, 2019

	Quarter Ended December 31, 2019						
	ACTUAL 12/31/2019	BUDGET 12/31/2019	VARIANCE	PERCENT	YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	PRIOR YEAR to DATE
NET PATIENT SERVICES REVENUES	21,560,662	22,270,100	(709,438)	-3.2%	21,560,662	22,270,100	20,681,642
Other Operating Revenues	1,428,786	1,775,555	(346,768)	-19.5%	1,428,786	1,775,555	1,944,923
NET OPERATING REVENUES	22,989,449	24,045,655	(1,056,206)	-4.4%	22,989,449	24,045,655	22,626,565
OPERATING EXPENSES							
Salaries	9,011,562	9,240,397	(228,834)	-2.5%	9,011,562	9,240,397	9,183,240
Benefits	2,566,793	3,107,424	(540,631)	-17.4%	2,566,793	3,107,424	2,701,943
Physician Fees	1,597,422	1,609,194	(11,772)	-0.7%	1,597,422	1,609,194	1,701,744
Supplies	4,126,607	4,065,475	61,131	1.5%	4,126,607	4,065,475	3,713,430
Other	3,225,429	3,494,229	(268,800)	-7.7%	3,225,429	3,494,229	3,223,714
Medicaid Enhancement Tax	1,022,103	1,032,622	(10,519)	-1.0%	1,022,103	1,032,622	995,532
Depreciation	1,097,718	1,141,398	(43,680)	-3.8%	1,097,718	1,141,398	1,113,970
Interest	251,010	259,502	(8,492)	-3.3%	251,010	259,502	259,086
TOTAL OPERATING EXPENSES	22,898,643	23,950,241	(1,051,597)	-4.4%	22,898,643	23,950,241	22,892,658
GAIN/(LOSS) FROM OPERATIONS	**90,805**	**95,414**	**(4,609)**	**-4.8%**	**90,805**	**95,414**	**(266,094)**
Net Margin	0.4%	0.4%	0.0%	-0.5%	0.4%	0.4%	-1.2%
TOTAL NON OPERATING REVENUES/EXPENSES	442,396	109,076	333,320	305.6%	442,396	109,076	219,883
GAIN AFTER NON OPERATING REVENUES	**$ 533,201**	**$ 204,490**	**$ 328,711**	**160.7%**	**$ 533,201**	**$ 204,490**	**$ (46,211)**
Stats:							
Salary and Benefits as a % of NPSR (xDSH)	56.5%	58.3%			56.5%	58.3%	
Benefits as a % of Salaries	28.5%	33.6%			28.5%	33.6%	
Operating Margin %	0.4%	0.4%			0.4%	0.4%	
EBITDA %	6.3%	6.2%			6.3%	6.2%	

GraniteOne
Statement of Operations
Quarter Ended December 31, 2019

	Quarter Ended December 31, 2019						
	ACTUAL 12/31/2019	BUDGET 12/31/2019	VARIANCE	PERCENT	YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	PRIOR YEAR TO DATE
NET PATIENT SERVICES REVENUES	-	-	-	0.0%	-	-	-
Other Operating Revenues	143,643	165,206	(21,563)	-13.1%	143,643	165,206	213,527
NET OPERATING REVENUES	143,643	165,206	(21,563)	-13.1%	143,643	165,206	213,527
OPERATING EXPENSES							
Salaries	105,350	150,705	(45,354)	-30.1%	105,350	150,705	187,191
Benefits	4,976	10,136	(5,161)	-50.9%	4,976	10,136	5,639
Physician Fees	-	-	-	0.0%	-	-	-
Supplies	-	-	-	0.0%	-	-	-
Other	-	18,848	(18,848)	-100.0%	-	18,848	20,697
Medicaid Enhancement Tax	-	-	-	0.0%	-	-	-
Depreciation	-	-	-	0.0%	-	-	-
Interest	-	-	-	0.0%	-	-	-
TOTAL OPERATING EXPENSES	110,326	179,689	(69,363)	-38.6%	110,326	179,689	213,526
GAIN/(LOSS) FROM OPERATIONS	**33,317**	**(14,483)**	**47,800**	**-330.0%**	**33,317**	**(14,483)**	**0**
Net Margin	23.2%	-8.8%	32.0%	-364.6%	23.2%	-8.8%	0.0%
TOTAL NON OPERATING REVENUES/EXPENSES	0	- 0	0	0.0%	0	0	0
GAIN AFTER NON OPERATING REVENUES	**$ 33,317**	**$ (14,483)**	**$ 47,800**	**-330.0%**	**$ 33,317**	**$ (14,483)**	**$ 0**

GraniteOne Health
Combined Balance Sheet
as of December 31, 2019

*includes topside entries

ASSETS	**12/31/2019**	**9/30/2019**
Current assets:		
Cash and cash equivalents	$ 72,168,569	$ 80,575,394
Short-term investments	3,537,757	4,021,270
Patient accounts receivable, net	99,337,254	97,193,426
Inventories	6,799,681	6,500,330
Prepaids and other current assets	15,631,744	14,086,468
Total current assets	**197,475,005**	**202,376,888**
Assets limited as to use	329,761,281	303,911,099
Property, plant and equipment, net	225,947,587	225,428,483
Intangible assets and other	21,270,429	20,935,985
Total assets	**$ 774,454,302**	**$ 752,652,455**
LIABILITIES AND NET ASSETS		
Current liabilities:		
Current portion of long-term debt	$ 5,203,681	$ 5,554,274
Accounts payable and accrued expenses	51,330,693	47,152,456
Accrued salaries, wages, and benefits	26,564,144	27,352,921
Estimated settlements to third-party payors	50,936,132	54,937,934
Total current liabilites	**134,034,651**	**134,997,585**
Accrued pension and other liabilites, net current portion	178,122,388	178,511,798
Long-term debt, excluding current portion	164,685,285	164,948,564
Total liabilites	**476,842,324**	**478,457,948**
Net assets:		
Without Donor Restrictions	237,407,142	230,578,497
With Donor Restrictions	60,204,836	43,616,011
Total net assets	**297,611,978**	**274,194,508**
Total liabilities and net assets	**$ 774,454,302**	**$ 752,652,455**

GraniteOne Health
Combining Balance Sheet
December 31, 2019

ASSETS	**GraniteOne**	**CMC Healthcare System**	**Huggins Hospital**	**Monadnock Community Hospital**	**Eliminations**	**Topside Entries**	**Total**
Current assets:							
Cash and cash equivalents	$ 34,069	$ 45,951,331	$ 12,864,771	$ 13,318,397	$ -	$ -	$ 72,168,569
Short-term investments	-	3,537,757	-	-	-	-	3,537,757
Patient accounts receivable, net	-	83,167,659	7,980,323	8,189,273	-	-	99,337,254
Inventories	-	4,912,485	568,210	1,318,986	-	-	6,799,681
Prepaids and other current assets	2,950,787	16,344,894	1,593,797	2,265,419	(7,523,154)	-	15,631,744
Intercompany Receivable	-	-	-	-	-	-	-
Total current assets	**2,984,856**	**153,914,126**	**23,007,101**	**25,092,075**	**(7,523,154)**	**-**	**197,475,005**
Assets limited as to use	-	187,366,983	65,469,559	76,924,739	-	-	329,761,281
Property, plant and equipment, net	-	143,124,465	46,414,047	37,400,952	-	(991,879)	225,947,587
Intangible assets and other	-	19,015,058	-	15,371	-	2,240,000	21,270,429
Total assets	**$ 2,984,856**	**$ 503,420,633**	**$ 134,890,708**	**$ 139,433,136**	**$ (7,523,154)**	**$ 1,248,121**	**$ 774,454,302**
LIABILITIES AND NET ASSETS							
Current liabilities:							
Current portion of long-term debt	$ -	$ 3,994,549	$ 623,694	$ 585,438	$ -	$ -	$ 5,203,681
Accounts payable and accrued expenses	2,974,150	45,414,269	4,503,512	5,961,916	(7,523,154)	-	51,330,693
Accrued salaries, wages, and benefits	-	20,323,545	3,174,549	3,066,050	-	-	26,564,144
Estimated settlements to third-party payors	-	6,410,228	24,756,120	19,769,784	-	-	50,936,132
Intercompany payable	-	-	-	-	-	-	-
Total current liabilites	**2,974,150**	**76,142,591**	**33,057,874**	**29,383,189**	**(7,523,154)**	**-**	**134,034,651**
Accrued pension and other liabilites, net current portion	-	172,387,665	2,857,862	2,876,861	-	-	178,122,388
Long-term debt, excluding current portion	-	121,725,136	19,404,044	23,556,106	-	-	164,685,285
Total liabilites	**2,974,150**	**370,255,392**	**55,319,780**	**55,816,155**	**(7,523,154)**	**-**	**476,842,324**
Net assets:							
Without Donor Restrictions	10,706	106,324,610	60,321,611	69,502,094	-	1,248,121	237,407,142
With Donor Restrictions	-	26,840,632	19,249,318	14,114,887	-	-	60,204,836
Total net assets	**10,706**	**133,165,241**	**79,570,928**	**83,616,981**	**-**	**1,248,121**	**297,611,978**
Total liabilities and net assets	**$ 2,984,856**	**$ 503,420,633**	**$ 134,890,708**	**$ 139,433,136**	**$ (7,523,154)**	**$ 1,248,121**	**$ 774,454,302**

GraniteOne Health
Combining Balance Sheet
September 30, 2019

ASSETS	**GraniteOne**	**CMC Healthcare System**	**Huggins Hospital**	**Monadnock Community Hospital**	**Eliminations**	**Topside Entries**	**Total**
Current assets:							
Cash and cash equivalents	$ (13,988)	$ 56,249,490	$ 10,897,609	$ 13,442,283	$ -	$ -	$ 80,575,394
Short-term investments	-	4,021,270	-	-	-	-	4,021,270
Patient accounts receivable, net	-	79,322,642	8,802,983	9,067,802	-	-	97,193,426
Inventories	-	4,600,802	573,385	1,326,142	-	-	6,500,330
Prepaids and other current assets	2,951,154	14,198,223	2,475,302	1,844,328	(7,382,538)	-	14,086,468
Intercompany Receivable	-	-	-	-	-	-	-
Total current assets	**2,937,166**	**158,392,427**	**22,749,279**	**25,680,555**	**(7,382,538)**	**-**	**202,376,888**
Assets limited as to use	-	167,020,035	62,858,907	74,032,157	-	-	303,911,099
Property, plant and equipment, net	-	143,111,363	45,839,002	37,239,464	-	(761,346)	225,428,483
Intangible assets and other	-	18,600,614	-	15,371	-	2,320,000	20,935,985
Total assets	**$ 2,937,166**	**$ 487,124,439**	**$ 131,447,188**	**$ 136,967,547**	**$ (7,382,538)**	**$ 1,558,654**	**$ 752,652,455**
LIABILITIES AND NET ASSETS							
Current liabilities:							
Current portion of long-term debt	$ -	$ 4,158,079	$ 618,470	$ 777,725	$ -	$ -	$ 5,554,274
Accounts payable and accrued expenses	2,959,776	38,985,902	5,083,579	7,505,736	(7,382,538)	-	47,152,456
Accrued salaries, wages, and benefits	-	22,973,477	2,386,134	1,993,309	-	-	27,352,921
Estimated settlements to third-party payors	-	11,456,467	23,856,120	19,625,347	-	-	54,937,934
Intercompany payable	-	-	-	-	-	-	-
Total current liabilites	**2,959,776**	**77,573,925**	**31,944,304**	**29,902,118**	**(7,382,538)**	**-**	**134,997,585**
Accrued pension and other liabilites, net current portion	-	172,049,836	3,193,584	3,268,379	-	-	178,511,798
Long-term debt, excluding current portion	-	121,883,751	19,514,216	23,550,597	-	-	164,948,564
Total liabilites	**2,959,776**	**371,507,512**	**54,652,103**	**56,721,094**	**(7,382,538)**	**-**	**478,457,948**
Net assets:							
Without Donor Restrictions	(22,610)	104,372,035	58,131,846	66,538,572	-	1,558,654	230,578,497
With Donor Restrictions	-	11,244,892	18,663,239	13,707,881	-	-	43,616,011
Total net assets	**(22,610)**	**115,616,927**	**76,795,085**	**80,246,452**	**-**	**1,558,654**	**274,194,508**
Total liabilities and net assets	**$ 2,937,166**	**$ 487,124,439**	**$ 131,447,188**	**$ 136,967,547**	**$ (7,382,538)**	**$ 1,558,654**	**$ 752,652,455**

GraniteOne Health
Statement of Cash Flows
Quarter Ended December 31, 2019

		December 2019
Change In Net Assets	$	23,417,470
Cash Flow from Operations:		
Depreciation/Amortization		6,820,572
Accrued Salaries, Wages and Related Exps		(788,777)
Patient Accounts Receivable, Net		(2,143,828)
Inventories		(299,351)
Other Current Assets		(1,545,276)
Accounts Payable and Accrued Expenses		4,178,237
Due to 3rd Party Payors		(4,001,801)
Pension and Insurance Obligations		253,162
Intangible Assets and Other		(1,984,829)
Accrued Pension and Other Liabilities, Net		(389,410)
Net Cash Flow from Operations		23,516,169
Cash Flow from Investing:		
Capital Expenditures		(7,339,674)
Net Cash Flow from Investing		(7,339,674)
Cash Flow from Financing:		
Current Portion of Long Term Debt		(350,593)
Funds Held by Trustee		1,432,801
Long Term Debt, Net of Current Portion		(263,279)
Net Cash Flow from Financing		818,929
Net Cash Flow for Fiscal Year 2020	$	16,995,424
Beginning Cash Balance, October 1, 2019	$	349,378,949
Ending Cash Balance, December, 2019	$	366,374,373

GraniteOne Health
Key Metrics
December 31, 2019

	Moody's A3	Moody's Baa1	S&P A-	Combined Actual YTD20	Combined Budget FY20	Combined Acutal FY19
Days Cash on Hand	183.50	184.60	232.30	197.26	203.34	199.03
Net Days revenue in A/R	47.00	45.10	46.00	61.51	40.44	60.96
Days in Accounts Payable	61.50	58.70	N/A	47.68	41.55	48.98
Cash to Comprehensive Debt	1.01	0.91	N/A	2.04	2.24	2.01
Operating Margin - before Topside Adjustments	1.60%	0.70%	2.30%	-2.79%	-0.75%	-1.32%
Operating Margin - after Topside Adjustments	1.60%	0.70%	2.30%	-2.98%	-0.75%	-1.52%
EBITDA Margin - after Topside Adjustment	7.80%	6.90%	10.70%	2.25%	4.39%	3.69%
Capital Expenditure % of Depreciation Expense	130.00%	100.00%	129.50%	106.28%	97.72%	121.59%
Current Ratio	1.80	2.10	N/A	1.47	1.51	1.50
Sal & Benefits as a % of NPSR	N/A	N/A	N/A	61.05%	59.02%	60.40%

CMC Healthcare System
Statement of Operations
for the 1st Quarter Ended December 31, 2019

1st Quarter (October thru December)						YTD				
1st Qtr Actual	1st Qtr Budget	1st Qtr $ Variance	1st Qtr % Variance	Prior Year 1st Qtr		YTD Actual	YTD Budget	YTD $ Variance	YTD % Variance	Prior YTD Actual
118,295	122,118	(3,823)	-3.13%	117,886	Net Patient Revenue	118,295	122,118	(3,823)	-3.13%	117,886
5,191	6,005	(814)	-13.56%	7,627	Other Operating Revenue	5,191	6,005	(814)	-13.56%	7,627
123,486	128,123	(4,637)	-3.62%	125,513	Total Revenue	123,486	128,123	(4,637)	-3.62%	125,513
					Expense					
59,579	59,984	405	0.68%	58,685	Salaries & Earned Time	59,579	59,984	405	0.68%	58,685
13,623	13,008	(615)	-4.73%	12,312	Fringe Benefits	13,623	13,008	(615)	-4.73%	12,312
25,838	26,970	1,132	4.20%	26,085	Supplies	25,838	26,970	1,132	4.20%	26,085
2,153	2,223	70	3.15%	1,586	Physician Fees	2,153	2,223	70	3.15%	1,586
15,648	15,723	75	0.48%	14,824	Other Operating	15,648	15,723	75	0.48%	14,824
5,513	5,574	61	1.09%	5,170	Medicaid Enhancement Tax	5,513	5,574	61	1.09%	5,170
1,091	1,117	26	2.33%	1,098	Interest	1,091	1,117	26	2.33%	1,098
4,265	4,494	229	5.10%	4,465	Depreciation / Amortization	4,265	4,494	229	5.10%	4,465
127,710	129,093	1,383	1.07%	124,225	Total Expense	127,710	129,093	1,383	1.07%	124,225
(4,224)	(970)	(3,254)	335.46%	1,288	Operating Gain (Loss)	(4,224)	(970)	(3,254)	335.46%	1,288
470	(322)	792	-245.96%	1,430	Non-Operating Revenue	470	(322)	792	-245.96%	1,430
$ (3,754)	$ (1,292)	$ (2,462)	190.56%	$ 2,718	Net Gain (Loss)	$ (3,754)	$ (1,292)	$ (2,462)	190.56%	$ 2,718
					Statistics					
61.9%	59.8%	2.1%	3.5%	60.2%	Salaries & Benefits as a % of NPSR	61.9%	59.8%	2.1%	3.5%	60.2%
22.9%	21.7%	1.2%	5.4%	21.0%	Benefits as a % of Salaries	22.9%	21.7%	1.2%	5.4%	21.0%
-3.4%	-0.8%	-2.7%	351.8%	1.0%	Operating Margin %	-3.4%	-0.8%	-2.7%	351.8%	1.0%
0.9%	3.6%	-2.7%	-74.7%	5.5%	EBITDA Margin %	0.9%	3.6%	-2.7%	-74.7%	5.5%

CMC Healthcare System
Balance Sheet
as of December 31, 2019

Assets	December 2019	September 2019
Current Assets		
Cash and Cash Equivalents	$ 45,951	$ 56,249
Short Term Investments	3,538	4,021
Patient Accounts Receivable, net	83,168	79,323
Inventories	4,912	4,601
Other Current Assets	16,345	14,198
Total Current Assets	153,914	158,392
Property, Plant & Equipment		
Property, Plant & Equipment	356,199	351,927
Accumulated Depreciation	(213,075)	(208,816)
Total Property, Plant & Equipment, net	143,124	143,111
Other Assets		
Intangible Assets and Other	19,015	18,601
Pension and Insurance Obligations	20,030	18,833
Board Designated and Donor Restricted	149,924	129,342
Held by Trustees	17,413	18,845
Total Other Assets	206,382	185,621
Total Assets	**$ 503,420**	**$ 487,124**

Liabilities and Net Assets	December 2019	September 2019
Current Liabilities		
Accounts Payable and Accrued Expenses	$ 45,414	$ 38,986
Accrued Salary, Wages and Related Exps.	20,323	22,973
Due to 3rd Party Payers	6,410	11,456
Current Portion of LT Debt	3,994	4,158
Total Current Liabilities	76,141	77,573
Long-Term Liabilities		
Accrued Pension and Other Liabilities	172,388	172,051
LT Debt, Net of Current Portion	121,725	121,884
Total Long-Term Liabilities	294,113	293,935
Net Assets		
Without Donor Restrictions	106,325	104,372
With Donor Restrictions	26,841	11,244
Total Net Assets	133,166	115,616
Total Liabilities and Net Assets	**$ 503,420**	**$ 487,124**

CMC Healthcare System
Statement of Cash Flows
for the Month Ended December 31, 2019

		December 2019
Change In Net Assets	**$**	**17,548**
Cash Flow from Operations:		
Depreciation / Amortization		4,259
Accrued Salaries, Wages and Related Exps		(2,650)
Patient Accounts Receivable, Net		(3,845)
Inventories		(312)
Other Current Assets		(2,147)
Accounts Payable and Accrued Expenses		6,428
Due to 3rd Party Payors		(5,046)
Pension and Insurance Obligations		(1,197)
Intangible Assets		(414)
Accrued Pension and Other Liabilities net		338
Net Cash Flow from Operations		**12,962**
Cash Flow from Investing:		
Capital Expenditures		(4,272)
Net Cash Flow from Investing		**(4,272)**
Cash Flow from Financing:		
Current Portion of Long Term Debt		(164)
Funds Held by Trustee		1,433
Long Term Debt, Net of Current Portion		(159)
Net Cash Flow from Financing		**1,110**
Net Cash Flow for Fiscal Year 2020	**$**	**9,800**
Beginning Cash Balance, October 1, 2019	**$**	**189,613**
Ending Cash Balance, December 31, 2019	**$**	**199,413**

CMC Healthcare System
Key Metrics
for the Month Ended December 31, 2019

	Moody's A3	Moody's Baa1	S&P A-	CMCHS YTD20	CMCHS BY20	CMCHS Sep-19
Days Cash on Hand	183.50	184.60	232.30	131.79	152.07	138.15
Net Days revenue in A/R	47.00	45.10	46.00	67.58	39.86	66.05
Days in Accounts Payable	61.50	58.70	N/A	56.74	50.83	59.07
Cash to Comprehensive Debt	1.01	0.91	N/A	1.45	1.65	1.53
Operating Margin	1.60%	0.70%	2.30%	-3.42%	-0.54%	-1.63%
EBITDA Margin	7.80%	6.90%	10.70%	0.92%	3.82%	2.69%
Capital Expenditure % of Depreciation Expense	130.00%	100.00%	129.50%	100.16%	74.06%	150.10%
Current Ratio	1.80	2.10	N/A	2.02	2.24	2.04
Sal & Benefits as a % of NPSR	N/A	N/A	N/A	61.88%	59.35%	60.99%
Paid FTE's	N/A	N/A	N/A	2,492.36	2,612.70	2,487.02

Catholic Medical Center
Statement of Operations
for the 1st Quarter Ended December 31, 2019

1st Quarter (October thru December)						YTD Actual				
1st Qtr Actual	1st Qtr Budget	1st Qtr $ Variance	1st Qtr % Variance	Prior Year 1st Qtr		YTD Actual	YTD Budget	YTD $ Variance	YTD % Variance	Prior YTD Actual
113,885	117,840	(3,955)	-3.36%	113,824	Net Patient Revenue	113,885	117,840	(3,955)	-3.36%	113,824
3,094	4,140	(1,046)	-25.27%	5,677	Other Operating Revenue	3,094	4,140	(1,046)	-25.27%	5,677
116,979	121,980	(5,001)	-4.10%	119,501	Total Revenue	116,979	121,980	(5,001)	-4.10%	119,501
					Expense					
46,456	46,736	280	0.60%	47,046	Salaries & Earned Time	46,456	46,736	280	0.60%	47,046
11,259	10,720	(539)	-5.03%	10,068	Fringe Benefits	11,259	10,720	(539)	-5.03%	10,068
25,521	26,705	1,184	4.43%	25,792	Supplies	25,521	26,705	1,184	4.43%	25,792
2,179	2,245	66	2.94%	1,726	Physician Fees	2,179	2,245	66	2.94%	1,726
13,655	13,881	226	1.63%	13,042	Other Operating	13,655	13,881	226	1.63%	13,042
5,513	5,574	61	1.09%	5,170	Medicaid Enhancement Tax	5,513	5,574	61	1.09%	5,170
1,015	1,041	26	2.50%	1,020	Interest	1,015	1,041	26	2.50%	1,020
3,977	4,210	233	5.53%	4,179	Depreciation / Amortization	3,977	4,210	233	5.53%	4,179
109,575	111,112	1,537	1.38%	108,043	Total Expense	109,575	111,112	1,537	1.38%	108,043
7,404	10,868	(3,464)	-31.87%	11,458	Operating Gain (Loss)	7,404	10,868	(3,464)	-31.87%	11,458
385	(379)	764	-201.58%	1,278	Non-Operating Revenue	385	(379)	764	-201.58%	1,278
$ 7,789	$ 10,489	$ (2,700)	-25.74%	$ 12,736	Net Gain (Loss)	$ 7,789	$ 10,489	$ (2,700)	-25.74%	$ 12,736
					Statistics					
50.7%	48.8%	1.9%	3.9%	50.2%	Salaries & Benefits as a % of NPSR	50.7%	48.8%	1.9%	3.9%	50.2%
24.2%	22.9%	1.3%	5.7%	21.4%	Benefits as a % of Salaries	24.2%	22.9%	1.3%	5.7%	21.4%
6.3%	8.9%	-2.6%	-29.0%	9.6%	Operating Margin %	6.3%	8.9%	-2.6%	-29.0%	9.6%
10.6%	13.2%	-2.6%	-19.8%	13.9%	EBITDA Margin %	10.6%	13.2%	-2.6%	-19.8%	13.9%

Catholic Medical Center
Balance Sheet
as of December 31, 2019

Assets	December 2019	September 2019
Current Assets		
Cash and Cash Equivalents	$ 39,436	$ 47,897
Short Term Investments	3,538	4,021
Patient Accounts Receivable, net	82,126	78,067
Inventories	4,912	4,601
Other Current Assets	14,671	12,781
Total Current Assets	144,683	147,367
Property, Plant & Equipment		
Property, Plant & Equipment	318,367	314,185
Accumulated Depreciation	(199,469)	(195,495)
Total Property, Plant & Equipment, net	118,898	118,690
Other Assets		
Intangible Assets and Other	12,325	11,869
Pension and Insurance Obligations	20,030	18,832
Board Designated and Donor Restricted	142,600	122,117
Held by Trustees	17,413	18,845
Total Other Assets	192,368	171,663
Total Assets	**$ 455,949**	**$ 437,720**

Liabilities and Net Assets	December 2019	September 2019
Current Liabilities		
Accounts Payable and Accrued Expenses	$ 43,059	$ 36,870
Accrued Salary, Wages and Related Exps.	16,016	18,604
Due to 3rd Party Payers	6,410	11,456
Intercompany Payable	2,066	991
Current Portion of LT Debt	3,760	3,924
Total Current Liabilities	71,311	71,845
Long-Term Liabilities		
Accrued Pension and Other Liabilities	161,093	160,697
LT Debt, Net of Current Portion	114,318	114,421
Total Long-Term Liabilities	275,411	275,118
Net Assets		
Without Donor Restrictions	82,387	79,512
With Donor Restrictions	26,840	11,245
Total Net Assets	109,227	90,757
Total Liabilities and Net Assets	**$ 455,949**	**$ 437,720**

Catholic Medical Center
Statement of Cash Flows
for the Month Ended December 31, 2019

		December 2019
Change In Net Assets	**$**	**18,470**
Cash Flow from Operations:		
Depreciation / Amortization		3,974
Accrued Salaries, Wages and Related Exps		(2,588)
Patient Accounts Receivable, Net		(4,059)
Inventories		(312)
Other Current Assets		(1,891)
Accounts Payable and Accrued Expenses		6,189
Accounts Payable / 3rd Parties		(5,046)
Accounts Payable / Affiliates		1,075
Pension and Insurance Obligations		(1,197)
Intangible Assets		(456)
Accrued Pension and Other Liabilities net		396
Net Cash Flow from Operations		**14,555**
Cash Flow from Investing:		
Capital Expenditures		(4,182)
Net Cash Flow from Investing		**(4,182)**
Cash Flow from Financing:		
Current Portion of Long Term Debt		(164)
Funds Held by Trustee		1,433
Long Term Debt, Net of Current Portion		(103)
Net Cash Flow from Financing		**1,166**
Net Cash Flow for Fiscal Year 2020	**$**	**11,539**
Beginning Cash Balance, October 1, 2019	**$**	**174,035**
Ending Cash Balance, December 31, 2019	**$**	**185,574**

Catholic Medical Center
Key Metrics
for the Month Ended September 30, 2019

	Moody's A3	Moody's Baa1	S&P A-	CMC YTD 20	CMC BY20	CMC Sep-19
Days Cash on Hand	183.50	184.60	232.30	142.01	173.60	146.19
Net Days revenue in A/R	47.00	45.10	46.00	69.44	40.35	67.54
Days in Accounts Payable	61.50	58.70	N/A	62.13	54.79	63.32
Cash to Comprehensive Debt	1.01	0.91	N/A	1.43	1.72	1.49
Operating Margin	1.60%	0.70%	2.30%	6.33%	9.05%	7.70%
EBITDA Margin	7.80%	6.90%	10.70%	10.60%	13.34%	11.92%
Capital Expenditure % of Depreciation Expense	130.00%	100.00%	129.50%	105.15%	79.07%	155.58%
Current Ratio	1.80	2.10	N/A	2.03	2.44	2.05
Sal & Benefits as a % of NPSR	N/A	N/A	N/A	50.68%	48.36%	50.45%
Paid FTE's	N/A	N/A	N/A	2,317.70	2,429.20	2,307.14
FTE's per Occupied Beds	N/A	N/A	N/A	5.59	5.78	5.78

Catholic Medical Center
Executive Summary of Statistics – Inpatient
for the 1st Qtr Ended December 31, 2019

1st Qtr (October thru December)						YTD				
Actual	Budget	Variance	% Var	Prior Year 1st Qtr		Actual	Budget	Variance	% Var	Prior YTD Actual
Admissions										
2,491	2,539	(48)	(1.9%)	2,421	Med-Surg	2,491	2,539	(48)	(1.9%)	2,421
211	207	4	1.9%	222	ICU	211	207	4	1.9%	222
2,702	**2,746**	**(44)**	**(1.6%)**	**2,643**	**Subtotal**	**2,702**	**2,746**	**(44)**	**(1.6%)**	**2,643**
103	99	4	4.0%	103	RMU	103	99	4	4.0%	103
254	283	(29)	(10.2%)	294	Maternity	254	283	(29)	(10.2%)	294
224	254	(30)	(11.8%)	269	Newborn	224	254	(30)	(11.8%)	269
581	**636**	**(55)**	**(8.6%)**	**666**	**Subtotal**	**581**	**636**	**(55)**	**(8.6%)**	**666**
34	36	(2)	(5.6%)	30	Special Care Nursery	34	36	(2)	(5.6%)	30
3,317	**3,418**	**(101)**	**(3.0%)**	**3,339**	**Hospital Total**	**3,317**	**3,418**	**(101)**	**(3.0%)**	**3,339**
Length of Stay (Calculated Using Discharges)										
4.80	5.12	(0.32)	(6.3%)	5.34	Med-Surg	4.80	5.12	(0.32)	(6.3%)	5.34
21.27	7.22	14.06	194.7%	6.59	ICU	21.27	7.22	14.06	194.7%	6.59
5.20	**5.27**	**(0.08)**	**(1.5%)**	**5.44**	**Subtotal**	**5.20**	**5.27**	**(0.08)**	**(1.5%)**	**5.44**
12.45	13.10	(0.65)	(5.0%)	12.71	RMU	12.45	13.10	(0.65)	(5.0%)	12.71
2.55	2.57	(0.01)	(0.5%)	2.51	Maternity	2.55	2.57	(0.01)	(0.5%)	2.51
2.19	2.17	0.02	0.9%	2.11	Newborn	2.19	2.17	0.02	0.9%	2.11
4.20	**4.05**	**0.15**	**3.7%**	**3.93**	**Subtotal**	**4.20**	**4.05**	**0.15**	**3.7%**	**3.93**
7.91	13.08	(5.17)	(39.5%)	17.00	Special Care Nursery	7.91	13.08	(5.17)	(39.5%)	17.00
5.06	**5.13**	**(0.07)**	**(1.3%)**	**5.25**	**Hospital Total**	**5.06**	**5.13**	**(0.07)**	**(1.3%)**	**5.25**
Patient Days										
12,709	12,990	(281)	(2.2%)	12,929	Med-Surg	12,709	12,990	(281)	(2.2%)	12,929
1,404	1,494	(90)	(6.0%)	1,462	ICU	1,404	1,494	(90)	(6.0%)	1,462
14,113	**14,484**	**(371)**	**(2.6%)**	**14,391**	**Subtotal**	**14,113**	**14,484**	**(371)**	**(2.6%)**	**14,391**
1,270	1,297	(27)	(2.1%)	1,309	RMU	1,270	1,297	(27)	(2.1%)	1,309
651	726	(75)	(10.3%)	739	Maternity	651	726	(75)	(10.3%)	739
462	551	(89)	(16.2%)	567	Newborn	462	551	(89)	(16.2%)	567
2,383	**2,574**	**(191)**	**(7.4%)**	**2,615**	**Subtotal**	**2,383**	**2,574**	**(191)**	**(7.4%)**	**2,615**
348	471	(123)	(26.1%)	510	Special Care Nursery	348	471	(123)	(26.1%)	510
16,844	**17,529**	**(685)**	**(3.9%)**	**17,516**	**Hospital Total**	**16,844**	**17,529**	**(685)**	**(3.9%)**	**17,516**

Catholic Medical Center
Executive Summary of Statistics – Inpatient
for the 1st Qtr Ended December 31, 2019

	1st Qtr (October thru December)						YTD				
	Actual	Budget	Variance	% Var	Prior Year 1st Qtr		Actual	Budget	Variance	% Var	Prior YTD Actual
Method						**Inpatient**					
Admit	3,214	3,319	(105)	(3.2%)	3,236	Admissions (excl. RMU)	3,214	3,319	(105)	(3.2%)	3,236
Days	15,574	16,232	(658)	(4.1%)	16,207	Patient Days	15,574	16,232	(658)	(4.1%)	16,207
# visits	1,717	1,820	(103)	(5.7%)	1,782	Emergency Room	1,717	1,820	(103)	(5.7%)	1,782
procedures	195	228	(33)	(14.5%)	270	EP Lab	195	228	(33)	(14.5%)	270
procedures	788	765	23	3.0%	718	Cardiac Cath	788	765	23	3.0%	718
# cases	892	971	(79)	(8.1%)	945	OR	892	971	(79)	(8.1%)	945
	136	175	(39)	(22.3%)	163	Endoscopy	136	175	(39)	(22.3%)	163
Billable Tests	113,715	118,259	(4,544)	(3.8%)	108,992	Laboratory	113,715	118,259	(4,544)	(3.8%)	108,992
exams	2,139	2,214	(75)	(3.4%)	2,113	CT	2,139	2,214	(75)	(3.4%)	2,113
exams	402	437	(35)	(8.0%)	427	MRI	402	437	(35)	(8.0%)	427
exams	393	383	10	2.6%	313	Vascular Intervention	393	383	10	2.6%	313
exams	1,139	1,190	(51)	(4.3%)	1,114	Ultrasound	1,139	1,190	(51)	(4.3%)	1,114
exams	4,864	5,269	(405)	(7.7%)	4,956	Radiology	4,864	5,269	(405)	(7.7%)	4,956
exams	198	194	4	2.1%	175	Nuclear Medicine	198	194	4	2.1%	175
treatment	12,466	14,060	(1,594)	(11.3%)	12,552	IP Rehab	12,466	14,060	(1,594)	(11.3%)	12,552
Method						**Inpatient RMU**					
Admit	103	99	4	4.0%	103	Total Admissions	103	99	4	4.0%	103
Days	1,270	1,297	(27)	(2.1%)	1,309	Patient Days	1,270	1,297	(27)	(2.1%)	1,309
exams	11,641	11,334	307	2.7%	11,480	RMU Rehab	11,641	11,334	307	2.7%	11,480

Catholic Medical Center
Executive Summary of Statistics – Outpatient
for the 1st Qtr Ended December 31, 2019

Method	1st Qtr (October thru December) Actual	Budget	Variance	% Var	Prior Year 1st Qtr		YTD Actual	Budget	Variance	% Var	Prior YTD Actual
						Observation Days					
	1,063	960	103	10.7%	712	Med-Surg	1,063	960	103	10.7%	712
	14	6	8	133.3%	8	Maternity	14	6	8	133.3%	8
	1,077	**966**	**111**	**11.5%**	**720**	**Hospital Total**	**1,077**	**966**	**111**	**11.5%**	**720**
						Outpatient					
# visits	6,609	6,539	70	1.1%	6,404	Emergency Room	6,609	6,539	70	1.1%	6,404
obs days	330	456	(126)	(27.6%)	232	Clincial Decision Unit	330	456	(126)	(27.6%)	232
procedures	5,689	5,705	(16)	(0.3%)	5,447	Non Invasive Cardiology	5,689	5,705	(16)	(0.3%)	5,447
procedures	2,004	1,888	116	6.1%	2,641	Non Invasive Cardiology - EKG	2,004	1,888	116	6.1%	2,641
procedures	570	558	12	2.2%	590	EP Lab	570	558	12	2.2%	590
procedures	735	566	169	29.9%	570	Cardiac Cath	735	566	169	29.9%	570
# cases	852	807	45	5.6%	820	OR	852	807	45	5.6%	820
# minutes	117,630	113,277	4,353	3.8%	113,770	PACU	117,630	113,277	4,353	3.8%	113,770
# visits	2,333	2,539	(206)	(8.1%)	2,194	Infusion	2,333	2,539	(206)	(8.1%)	2,194
billable tests	111,935	122,593	(10,658)	(8.7%)	116,087	Laboratory	111,935	122,593	(10,658)	(8.7%)	116,087
billable tests	30,092	29,468	624	2.1%	30,880	Lab Client Billed	30,092	29,468	624	2.1%	30,880
procedures	1,112	1,231	(119)	(9.7%)	1,074	Endoscopy	1,112	1,231	(119)	(9.7%)	1,074
# cases	537	552	(15)	(2.7%)	554	Sleep Center	537	552	(15)	(2.7%)	554
exams	3,613	3,784	(171)	(4.5%)	3,657	CT	3,613	3,784	(171)	(4.5%)	3,657
exams	903	922	(19)	(2.1%)	783	MRI	903	922	(19)	(2.1%)	783
exams	2,618	2,762	(144)	(5.2%)	2,863	Mammography	2,618	2,762	(144)	(5.2%)	2,863
exams	686	456	230	50.4%	378	Vascular Intervention	686	456	230	50.4%	378
exams	2,506	2,747	(241)	(8.8%)	2,641	Ultrasound	2,506	2,747	(241)	(8.8%)	2,641
exams	5,954	5,873	81	1.4%	6,159	Radiology	5,954	5,873	81	1.4%	6,159
exams	716	676	40	5.9%	591	Nuclear Medicine	716	676	40	5.9%	591
treatments	14,556	15,063	(507)	(3.4%)	14,123	Rehab Services	14,556	15,063	(507)	(3.4%)	14,123
treatments	1,926	2,132	(206)	(9.7%)	1,869	Cardiac Rehab	1,926	2,132	(206)	(9.7%)	1,869
# visits	6,088	6,035	53	0.9%	6,008	OP Clinics	6,088	6,035	53	0.9%	6,008
# visits	638	841	(203)	(24.1%)	503	Pain Clinic	638	841	(203)	(24.1%)	503
RVUs	29,969	27,344	2,625	9.6%	23,503	Primary Care	29,969	27,344	2,625	9.6%	23,503
RVU's	3,108	3,538	(430)	(12.2%)	3,477	Urgent Care	3,108	3,538	(430)	(12.2%)	3,477
RVU's	112	125	(13)	(10.4%)	-	Addiction Medicine	112	125	(13)	(10.4%)	-
RVU's	1,801	1,839	(38)	(2.1%)	1,577	Neurology	1,801	1,839	(38)	(2.1%)	1,577
RVU's	822	873	(51)	(5.8%)	630	Rheumatology	822	873	(51)	(5.8%)	630
RVU's	2,050	2,340	(290)	(12.4%)	1,465	OBGYN	2,050	2,340	(290)	(12.4%)	1,465
RVUs	56,983	57,879	(896)	(1.5%)	53,801	NEHI	56,983	57,879	(896)	(1.5%)	53,801
RVU's	9,056	9,448	(392)	(4.1%)	8,616	Gastroenterology	9,056	9,448	(392)	(4.1%)	8,616
RVUs	19,618	23,706	(4,088)	(17.2%)	21,045	Surgical Care Group	19,618	23,706	(4,088)	(17.2%)	21,045
RVU's	1,343	-	1,343	100.0%	-	CMC Orthopedics	1,343	-	1,343	100.0%	-
RVU's	16,246	15,218	1,028	6.8%	13,290	Cardiothoracic Surgeons	16,246	15,218	1,028	6.8%	13,290
RVU's	1,263	1,889	(626)	(33.1%)	1,670	Vein Center	1,263	1,889	(626)	(33.1%)	1,670
RVUs	24,135	26,454	(2,319)	(8.8%)	26,454	Hospitalists	24,135	26,454	(2,319)	(8.8%)	26,454

CMC Healthcare System
Consolidating Statement of Operations
for the Three Months Ending December 31, 2019

	CMC		Physician Practice Associates		Alliance Health Services		Alliance Resources		Alliance Ambulatory	
	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget
NET PATIENT REVENUE	113,885	117,840	-	-	4,410	4,278	-	-	-	-
OTHER OPERATING REVENUE	3,094	4,140	4,795	4,779	149	151	399	387	677	656
TOTAL OPERATING REVENUE	116,979	121,980	4,795	4,779	4,559	4,429	399	387	677	656
EXPENSES										
Salaries	46,456	46,736	13,702	13,937	3,508	3,325	-	-	-	-
Fringe	11,259	10,720	1,437	1,414	733	720	-	-	-	-
Total Salaries and Fringe	57,715	57,456	15,139	15,351	4,241	4,045	-	-	-	-
SUPPLIES AND OTHER EXPENSES										
Supplies	25,521	26,705	-	-	308	247	-	-	-	-
Physician Fees	2,179	2,245	8	8	-	-	-	-	-	-
Other Expenses	13,655	13,881	663	721	1,311	1,326	242	231	-	-
Medicaid Enhancement Tax	5,513	5,574	-	-	-	-	-	-	-	-
Interest	1,015	1,041	-	-	-	-	-	-	-	-
Depreciation & Amortization	3,977	4,210	-	-	8	9	153	152	-	-
TOTAL OTHER EXPENSES	51,860	53,656	671	729	1,627	1,582	395	383	-	-
Total Expenses	109,575	111,112	15,810	16,080	5,868	5,627	395	383	-	-
INCOME(LOSS) FROM OPERATIONS	7,404	10,868	(11,015)	(11,301)	(1,309)	(1,198)	4	4	677	656
NON-OPERATING GAINS, NET	385	(379)	(10)	(5)	-	-	-	-	1	2
EXCESS/(DEFICIENCY) OF REVENUES OVER EXPENSES	7,789	10,489	(11,025)	(11,306)	(1,309)	(1,198)	4	4	678	658

CMC Healthcare System
Consolidating Statement of Operations
for the Three Months Ending December 31, 2019

	Doctor's Medical Associates		Alliance Enterprises		MOB		NHML		St Peters Home		Eliminations		CMC System	
	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget
NET PATIENT REVENUE	-	-	-	-	-	-	-	-	-	-	-	-	118,295	122,118
OTHER OPERATING REVENUE	34	29	-	-	498	527	-	-	867	902	(5,322)	(5,566)	5,191	6,005
TOTAL OPERATING REVENUE	34	29	-	-	498	527	-	-	867	902	(5,322)	(5,566)	123,486	128,123
EXPENSES														
Salaries	-	-	-	-	-	-	-	-	653	725	(4,740)	(4,739)	59,579	59,984
Fringe	-	-	-	-	-	-	6	6	188	148	-	-	13,623	13,008
Total Salaries and Fringe	-	-	-	-	-	-	6	6	841	873	(4,740)	(4,739)	73,202	72,992
SUPPLIES AND OTHER EXPENSES														
Supplies	-	-	-	-	-	-	-	-	9	18	-	-	25,838	26,970
Physician Fees	-	-	-	-	-	-	-	-	-	-	(34)	(30)	2,153	2,223
Other Expenses	19	24	-	-	233	289	-	-	73	48	(548)	(797)	15,648	15,723
Medicaid Enhancement Tax	-	-	-	-	-	-	-	-	-	-	-	-	5,513	5,574
Interest	-	-	-	-	76	76	-	-	-	-	-	-	1,091	1,117
Depreciation & Amortization	-	-	-	-	78	76	-	-	49	47	-	-	4,265	4,494
TOTAL OTHER EXPENSES	19	24	-	-	387	441	-	-	131	113	(582)	(827)	54,508	56,101
Total Expenses	19	24	-	-	387	441	6	6	972	986	(5,322)	(5,566)	127,710	129,093
INCOME(LOSS) FROM OPERATIONS	15	5	-	-	111	86	(6)	(6)	(105)	(84)	-	-	(4,224)	(970)
NON-OPERATING GAINS, NET	-	-	-	-	-	-	(6)	(5)	100	65	-	-	470	(322)
EXCESS/(DEFICIENCY) OF REVENUES OVER EXPENSES	15	5	-	-	111	86	(12)	(11)	(5)	(19)	-	-	$ (3,754)	$ (1,292)

Report to
The Finance Committee

Thursday, February 20, 2020
7:30 AM – 9:00 AM
Conference Room 5

Month Ending January 31, 2020

Index

The purpose of this document is to provide an overview of the month-end results for the period ending January 31, 2020 compared to the budget for Monadnock Community Hospital. This summary should be read in conjunction with the financial statements contained in this package.

EXECUTIVE SUMMARY

The Total Operating Gain for the month was $108K which was better than budget by $76K as the margin was budgeted to be a Gain of $33K. On a year-to-date basis, the total margin is $199K versus a budget of $130K resulting in a variance of $69K. Total Gross Patient Service Revenues were ($315K) or (2.06%) lower than budget for the month. Year-to-date Gross Patient Service Revenues are ($1.5M) or (3%) under budget. Inpatient Revenues were ($320K) or (19.76%) under budget due to a continuation of lower than anticipated volumes in the Operating Room ($320K). Outpatient Revenues were ($310K) or (2.70%) lower than budget. This variance was driven by volumes coming in lower than budget in Imaging Services ($237K) and the Pharmacy ($142K). Conversely, volumes were up versus budget in Physical Therapy by 19% which drove revenues up by $119K.

Physician Revenues came in above budget again this month and were $315K or 14% favorable. The Primary Care departments comprised $185K of this variance driven by increased volumes in Monadnock Regional Pediatrics $125K, Monadnock Internal Medicine $28K, and New Ipswich Family Medicine $27K. Volumes in the Specialty areas were also up, resulting in positive revenue variances in Physiatry $93K and Monadnock Behavioral Health $55K. Offers have been extended to two Behavioral Health Pysch Advanced Practice Nurse Practitioners, and management is actively interviewing one Physician Assistant in Physiatry. All of these new positions were budgeted. On a year-to-date basis, overall Health Partners WRVU volumes are 3% better than budget and 10% higher than YTD January 2019.

Other Revenue and Net Assets Released were ($137K) or (23%) lower than budget for the month. This is primarily driven by Rebates & Refunds ($45K) and Incentive Payments ($31K) coming in under budget.

Overall Revenue Deductions were $7.3M in January, which was $157K lower than budget. The contractual allowances (excluding DSH) month to date were 46.5% compared to a budget of 46.3%. During the month of January, the organization recorded $360K for DSH. In aggregate, total revenue deductions were 49.0% compared to a budget of 49.1%. On a year-to-date basis, total revenue deductions are 49.6% compared to a budget of 49.4%.

Total Operating Expenses came in $371K below budget this month and were driven primarily by lower than anticipated Benefits expenses $403K and Affiliation Expense $46K. Of note, Affiliation Expenses are expected to continue to be favorable this fiscal year due to the treatment of expenses associated with the DHH-GOH combination budgeted originally in operations, but now flowing through the Combination Agreement Expense (non-operating expense). Conversely, Purchased Services-Non Revenue were ($160K) higher than budget primarily due to Contract Management Fees ($52K) due to eCW super user training, Physician Recruitment Expense ($30K) associated with Monadnock Surgical Associates, and Recruitment Agency Fees ($30K) for physician retained search expenses.

Total Salary expenses were ($46K) or (1.48%) above budget. Of note, Outside Service expense was up by ($26K) due to an increase in Medical Surgical and Physical Therapy contracted labor. Total January Hospital FTE's (excluding Other Outside Services) year-to-date are 490 compared to a budget of 516. Total year-to-date Other Outside Service FTE's are 28 versus a budget of 24.

The Finance team is partnering monthly with project owners of the key FY 2020 Financial Recovery Plan (FRP) initiatives to track progress/effort and financial performance. FRP initiatives are tracked monthly by Finance and reported quarterly to Senior Leadership and the Board.

Operational Highlights:

Revenues:

- In January, total Gross Patient Service Revenues were $15.0M. This was ($315K) or (2%) lower than budget for the month.

- Inpatient Revenue was ($320K) or (20%) lower than budget for the month. Outpatient Revenue was ($310K) or (3%) lower than budget. Physician Revenue was $315K or 14% higher than budget for the month.

- The ($320K) lower than budget results in Inpatient Revenue were driven by negative results in the OR.

    - Patient Days were 4% higher than budget for the month and were driven by Med/Surg which was 6% higher than budget. Admissions were 3% higher than budget and were driven by OB which was 7% higher than budget. Discharges were 2% lower than budget and were driven by OB which was 26% lower than budget.

- The ($310K) lower than budget results in Outpatient Revenue were attributed primarily to negative results in Imaging and Pharmacy. Conversely, there were positive results in Physical Therapy. Outpatient visits for the Hospital were 1% lower than budget for the month.

- The $315K higher than budget results in Physician Revenue were attributed primarily to positive results in Monadnock Regional Pediatrics, Physiatry, Monadnock Behavioral Health and Monadnock Anesthesia Associates.

    - Practice volumes were 9% higher than budget and were driven by all areas except for Monadnock Surgical Associates, Monadnock Family Care, Jaffrey Family Medicine and Monadnock Orthopaedic Associates which came in 26%, 8%, 7% and 6% lower than budget for the month respectively.

- Other Revenue and Net Assets Released were ($137K) lower than budget for the month. This is primarily driven by Rebates and Refunds ($45K) and Incentive Payments ($31K) coming in lower than budgeted.

Revenue Deductions:

- Overall Revenue Deductions were $7.3M in January, which was $157K lower than budget. The contractual allowances (excluding DSH) month to date were 46.5% compared to a budget of 46.3%. During the month of January, the organization recorded $360K for DSH. In aggregate, total revenue deductions were 49.0% compared to a budget of 49.1%. On a year-to-date basis, total revenue deductions are 49.6% compared to a budget of 49.4%.

Expenses:

- Overall operating expenses were $8.0M for the month. This was $371K lower than budget for the month.

- During the month of January there were increases in:
    - **Salaries:** Expenses were $3.2M compared to a budget of $3.1M.
    - **Purchased Services Non-Revenue:** Expenses were $650K compared to a budget of $490K.

- Alternatively, there were decreases in:
    - **Benefits:** Expenses were $819K compared to a budget of $1.2M.
    - **Other:** Expenses were $134K compared to a budget of $227K.

Operating Margin:

- The net margin for the month was $108K. This is $76K better than budget.

Non-Operational Highlights:

Investment Income:

- Investment Income for the month was $63K. This was $11K higher than budget. This was driven by timing of interest and dividends from investments and realized gains.

Increase in Unrestricted Net Assets:

- The total increase in Unrestricted Net Assets for the month was $534K. This was $438K higher than budget. This was driven by unrealized gains from investments.

Balance Sheet Highlights (comparatively to 09/30/19):

- Accrual for estimated 3rd party payors is up $266K or 1.3% which is primarily driven by an increase in Medicare reserves.

- Property and equipment is up $346K or 1.0% which is primarily driven by timing of capital acquisitions for FY'20 YTD. Average age of plant as of 1/31/20 is 15.3 years versus 14.0 years on 9/30/19.

- Other assets are up $43K or 1.5% which is primarily driven by changes in the market value of the organization's two SWAP agreements.

- Total Liabilities are down $1.1M or 3.3% which is primarily driven by a decrease in the organization's accrued accounts payable expenses.

- Total Net Assets increased by $4.0M or 4.9% driven by investment gains.

Statement of Cash Flows Highlights:

Overall, the change in cash and cash equivalents is down $234K or 1.9% compared to the same period last year. Year-to-date cash from operations is $983K lower than year-to-date at 1/31/19. This is primarily driven by changes in 3rd party liabilities.

MONADNOCK COMMUNITY HOSPITAL
STATEMENT OF OPERATIONS AND CHANGE IN NET ASSETS
For the Four Months Ending January 31, 2020

	MONTH TO DATE				LAST YEAR		YEAR TO DATE				LAST YEAR
Line	ACTUAL 01/31/2020	BUDGET 01/31/2020	VARIANCE	PERCENT	MTD	DESCRIPTION	ACTUAL 01/31/2020	BUDGET 01/31/2020	VARIANCE	PERCENT	YTD
						PATIENT SERVICES REVENUE					
1	1,298,938	1,618,789	(319,850)	(19.76%)	1,590,567	Inpatient Revenue	6,052,709	6,446,547	(393,838)	(6.11%)	6,493,926
2	11,174,947	11,484,971	(310,025)	(2.70%)	11,100,679	Outpatient Revenue	42,723,530	44,381,835	(1,658,305)	(3.74%)	41,921,296
3	2,509,236	2,194,660	314,576	14.33%	2,212,043	Physician Revenue	9,160,903	8,645,674	515,229	5.96%	8,090,631
4	**14,983,121**	**15,298,420**	**(315,299)**	**(2.06%)**	**14,903,289**	**TOTAL PATIENT SERVICES REVENUE**	**57,937,143**	**59,474,057**	**(1,536,914)**	**(2.58%)**	**56,505,852**
						REVENUE DEDUCTIONS					
5	6,963,937	7,080,246	116,309	1.64%	6,908,427	Contractual Adjustments	27,392,851	27,715,386	322,536	1.16%	26,983,372
6	(360,417)	(360,417)	0	(0.00%)	(360,417)	DSH Funding	(1,441,668)	(1,441,667)	1	(0.00%)	(1,441,668)
7	186,581	178,076	(8,505)	(4.78%)	138,557	Policy Discounts	636,107	705,722	69,615	9.86%	454,240
8	172,366	162,685	(9,681)	(5.95%)	149,630	Charity Care	562,780	650,267	87,487	13.45%	520,903
9	385,669	444,535	58,866	13.24%	473,370	Bad Debt	1,591,426	1,779,243	187,818	10.56%	1,713,642
10	**7,348,136**	**7,505,125**	**156,989**	**2.09%**	**7,309,567**	**TOTAL REVENUE DEDUCTIONS**	**28,741,495**	**29,408,952**	**667,457**	**2.27%**	**28,230,489**
11	**7,634,985**	**7,793,294**	**(158,309)**	**(2.03%)**	**7,593,722**	**NET PATIENT SERVICES REVENUES**	**29,195,648**	**30,065,105**	**(869,457)**	**(2.89%)**	**28,275,363**
12	443,259	573,332	(130,072)	(22.69%)	455,083	Other Operating Revenues	1,803,388	2,259,992	(456,605)	(20.20%)	2,311,655
13	22,886	29,631	(6,745)	(22.76%)	22,342	Net Assets Released from Restrictions	91,544	118,525	(26,981)	(22.76%)	110,693
14	**8,101,131**	**8,396,258**	**(295,127)**	**(3.51%)**	**8,071,147**	**NET OPERATING REVENUES**	**31,090,579**	**32,443,623**	**(1,353,043)**	**(4.17%)**	**30,697,711**
						OPERATING EXPENSES					
15	3,164,604	3,118,445	(46,159)	(1.48%)	3,183,509	Salaries	12,176,166	12,358,842	182,676	1.48%	12,366,750
16	818,754	1,222,050	403,296	33.00%	1,059,873	Benefits	3,385,548	4,329,474	943,927	21.80%	3,761,816
17	539,195	525,897	(13,298)	(2.53%)	546,036	Fees-Physicians	2,136,617	2,135,091	(1,526)	(0.07%)	2,247,780
18	649,727	489,975	(159,752)	(32.60%)	439,550	Purchased Services-Non Revenue	1,994,024	1,880,052	(113,972)	(6.06%)	1,714,959
19	6,280	51,800	45,521	87.88%	40,108	Affiliation Expense	28,332	207,202	178,870	86.33%	61,805
20	175,414	162,330	(13,084)	(8.06%)	152,946	Purchased Services Revenue	687,936	628,395	(59,541)	(9.48%)	642,697
21	645,027	657,648	12,621	1.92%	655,886	Supplies	2,689,884	2,575,238	(114,646)	(4.45%)	2,455,314
22	727,742	737,771	10,029	1.36%	820,225	Oncology Drugs	2,811,137	2,898,300	87,163	3.01%	2,741,452
23	113,167	113,208	41	0.04%	92,582	Utilities	417,915	453,712	35,797	7.89%	428,901
24	133,968	158,919	24,951	15.70%	132,319	Repairs/Maint Contracts	476,935	555,147	78,213	14.09%	511,278
25	45,659	44,724	(935)	(2.09%)	43,231	Leases/Rentals	202,763	232,410	29,647	12.76%	268,397
26	52,934	45,325	(7,609)	(16.79%)	43,663	Insurance	180,374	176,157	(4,217)	(2.39%)	168,932
27	133,615	227,038	93,423	41.15%	148,864	Other	546,269	641,831	95,562	14.89%	512,784
28	362,638	380,466	17,828	4.69%	389,265	Depreciation	1,460,355	1,521,864	61,508	4.04%	1,503,235
29	83,340	83,737	398	0.48%	89,816	Interest	334,349	343,239	8,890	2.59%	348,902
30	340,701	344,207	3,506	1.02%	331,844	Medicaid Enhancement Tax	1,362,804	1,376,829	14,025	1.02%	1,327,376
31	**7,992,764**	**8,363,543**	**370,779**	**4.43%**	**8,169,718**	**TOTAL OPERATING EXPENSES**	**30,891,407**	**32,313,783**	**1,422,376**	**4.40%**	**31,062,376**
32	**108,367**	**32,715**	**75,652**	**(231.24%)**	**(98,571)**	**GAIN/(LOSS) FROM PATIENT CARE**	**199,172**	**129,839**	**69,333**	**53.40%**	**(364,665)**
33	***1.34%***	***0.39%***	***0.95%***	***(243.31%)***	***(1.22%)***	***Net Margin***	***0.64%***	***0.40%***	***0.24%***	***60.07%***	***(1.19%)***
						NON OPERATING REVENUES/EXPENSES					
34	0	204	(204)	(100.00%)	0	Gain/(Loss) on sale/disposal of asset	0	816	(816)	(100.00%)	6,000
35	62,923	52,241	10,682	20.45%	440,368	Investment Income	497,857	208,963	288,894	138.25%	789,977
36	0	0	0		0	Grant Income	0	0	0		0
37	0	0	0		0	Gain/(Loss) on Swap Agreement	0	0	0		0
38	0	0	0		0	Loss on Extinguishment of Debt	0	0	0		0
39	(29,140)	16,708	(45,848)	(274.40%)	(25,707)	Unrestricted Gifts (Net of Philanthropy)	81,506	35,690	45,816	128.37%	5,999
40	(12,183)	0	(12,183)		0	Combination Agreement [Expense]	(45,765)	0	(45,765)		0
41	0	(22,413)	22,413	100.00%	0	Other Non-Operating Revenue/[Expense]	(69,602)	(89,652)	20,050	22.36%	(167,432)
42	**21,600**	**46,740**	**(25,140)**	**(53.79%)**	**414,661**	**TOTAL NON OPERATING REVENUES/EXPENSES**	**463,996**	**155,816**	**308,180**	**197.78%**	**634,544**
43	**129,967**	**79,455**	**50,512**	**63.57%**	**316,090**	**GAIN AFTER NON OPERATING REVENUES**	**663,168**	**285,655**	**377,512**	**132.16%**	**269,879**
44	836,196	0	836,196		2,620,582	Change in Net Unrealized Gains and Losses	2,780,483	0	2,780,483		(2,702,205)
45	(434,172)	0	(434,172)		(63,575)	Unrealized G/(L) on Derivative Financial Instrument	(42,654)	0	(42,654)		(564,053)
46	2,289	16,669	(14,379)	(86.27%)	2,449	Restricted Assets Used for Purchase of Equip	96,805	66,675	30,130	45.19%	77,195
47	0	0	0		0	Net Assets Released from Restriction - Other	0	0	0		0
48	**534,280**	**96,124**	**438,156**	**455.83%**	**2,875,547**	**INCREASE IN UNRESTRICTED NET ASSETS**	**3,497,802**	**352,330**	**3,145,472**	**892.76%**	**(2,919,183)**

Monadnock Community Hospital
Statement of Operations
Operating Expense Definitions

Line	Operating Expense	Description
15	Salaries	Wages Paid to Employed Staff and Providers; Other Outside Services; Accrued Earned Time
16	Benefits	Indirect and Non-cash Compensation to Employees including Medical Insurance, Retirement Benefits, Employment Taxes
17	Fees-Physicians	Non-employed physicians providing medical services at MCH that MCH bills for; Medical Director Stipends; Locum Physicians
18	Purchased Services-Non Revenue	Outside services performed for the Hospital not involving the delivery of medical services, including:
		Financial & Administrative - collections, consulting, recruiting, auditing
		Facility Support - contract management of food & environmental services
		IT & Telecom - hardware, software support and maintenance
19	Affiliation Expense	Expense related to GOH Affiliation.
20	Purchased Services Revenue	Payment for medical services provided by a 3rd party vendor at the Hospital that MCH bills for (ie MRI, Lab)
21	Supplies	Consumable items such as medical and office supplies, drugs, food
22	Oncology Drugs	Drugs specific to the treatment of cancer and other genetic diseases (fabrazyme, remicade, rituxan)
23	Utilities	Fuel, Electricity, Telephone, Data
24	Repairs/Maint Contracts	Service agreements for equipment maintenance; Repairs to equipment: Building maintenance
25	Leases/Rentals	Rental expense for physician offices; Property Taxes; Miscellaneous Equipment Rental
26	Insurance	Coverage for exposure to liability, general and property losses
27	Other	Catch-all for various expenses such as Dues/Licenses, Postage, Conferences, Minor Equipment
28	Depreciation	Cost conversion of tangible or fixed assets to an operating expense over the estimated useful life of the asset
29	Interest	Expense related to the cost of borrowing; ie organizational debt, line of credit, amortization of issuance costs
30	Medicaid Enhancement Tax	Tax liability on hospital net patient service revenue

MONADNOCK COMMUNITY HOSPITAL
BALANCE SHEET
01/31/20

	01/31/2020	12/31/2019	NET CHANGE	01/31/2019	09/30/2019
ASSETS					
Current Assets:					
Cash and cash equivalents	$12,322,844	$13,318,395	(995,551)	$12,556,652	$13,442,283
Patient Accounts Receivable, Net	8,631,149	7,824,723	806,426	8,539,547	8,703,252
Supplies	1,325,302	1,318,986	6,316	1,374,795	1,326,142
Pre-paid expenses and other current assets	1,863,205	2,093,397	(230,192)	2,176,836	1,659,035
Current portion of notes receivable	76,099	76,099	-	164,377	89,370
Accrual for estimated settlements with third-party payors	(20,839,940)	(20,718,350)	(121,590)	(20,201,509)	(20,573,913)
Total current assets	3,378,659	3,913,250	(534,591)	4,610,698	4,646,169
Assets whose use is limitted or restricted:					
Under indenture agreement, held by Trustee	0	0	-	0	0
By Board Principally for capital improvements	63,620,360	62,703,392	916,968	52,592,656	60,217,817
Investments	14,173,823	14,114,887	58,936	12,715,060	13,707,880
Total assets whose use is limited or restricted	77,794,183	76,818,279	975,904	65,307,716	73,925,697
Property and equipment, net	36,336,053	36,175,260	160,793	36,245,999	35,990,022
Medical office building and related assets, net	1,217,776	1,225,693	(7,917)	1,312,773	1,249,442
Other noncurrent assets:					
Other long-term receivables, net of current portion	35,371	15,371	20,000	46,121	15,371
Other assets	(2,869,031)	(2,434,860)	(434,171)	(1,543,662)	(2,826,378)
Total other noncurrent assets	(2,833,660)	(2,419,489)	(414,171)	(1,497,541)	(2,811,007)
Total assets	115,893,011	115,712,993	180,018	105,979,645	113,000,323
LIABILITIES AND NET ASSETS					
Current Liabilities:					
Accounts payable and accrued expenses	5,036,181	4,647,425	388,756	4,145,686	6,191,247
Accrued salaries, wages, and benefits	2,573,166	3,307,043	(733,877)	2,973,208	2,234,302
Current portion of long-term debt	429,843	483,242	(53,399)	416,385	642,346
Current portion of capital lease obligations	85,990	102,196	(16,206)	97,322	135,379
Total current liabilites	8,125,180	8,539,906	(414,726)	7,632,601	9,203,274
Long-term debt, excluding current portion	23,198,774	23,197,247	1,527	23,717,715	23,191,739
Capital lease obligations, excluding current portion	358,859	358,859	-	336,999	358,859
Total liabilites	31,682,813	32,096,012	(413,199)	31,687,315	32,753,872
Net assets:					
Unrestricted	66,538,572	66,538,572	-	64,496,453	64,496,453
Temporary restricted	4,848,705	4,768,046	80,659	3,902,510	4,626,354
Permanently restricted	9,325,119	9,346,841	(21,722)	8,812,550	9,081,526
Increase in unrestricted net assets ytd	3,497,802	2,963,522	534,280	(2,919,183)	2,042,118
Total net assets	84,210,198	83,616,981	593,217	74,292,330	80,246,451
Total liabilities and net assets	115,893,011	115,712,993	180,018	105,979,645	113,000,323

MONADNOCK COMMUNITY HOSPITAL
STATEMENT OF CASH FLOWS
AS OF JANUARY 31, 2020

	Fiscal Year To Date	YTD January 2019
Cash Flow from operating activities		
Change in net assets	3,963,745	(3,621,169)
Adjustments to reconcile change in net assets to net cash provided (used) by operating activities		
Depreciation	1,460,355	1,503,235
Provision for uncollectible accounts	1,591,426	1,713,642
Losses (gains) on disposition of equipment	-	(6,000)
Net realized and unrealized losses (gains) on investments	(3,470,423)	2,891,729
Interest rate swap	42,654	564,053
Loss on extinguishment of debt	-	-
Increase in cash surrender value of life insurance	-	-
Restricted contributions and investment income	(25,153)	(58,791)
(Increase) decrease in		
Patient accounts receivable	(1,519,323)	(1,144,520)
Pledges Receivable	-	-
Supplies	840	35,205
Prepaid expenses	(204,170)	(629,111)
Notes Receivable	(6,729)	(8,906)
Accrual for estimated third-party payor settlements	266,027	1,424,458
Increase (decrease) in		
Accounts payable and accrued expenses	(1,155,064)	(1,172,759)
Accrued salaries, wages and benefits	338,864	775,239
Net cash provided by operating activities	1,283,049	2,266,304
Cash flows from investing activities		
Purchases of property and equipment, net	(1,774,720)	(1,805,618)
Investments, net	(398,063)	(380,759)
Net cash used by investing activities	(2,172,783)	(2,186,376)
Cash flows from financing activities		
Proceeds from restricted contributions received	25,153	58,791
Payments on long-term debt, net	(205,470)	(190,941)
Principal payments on capital lease obligations, net	(49,389)	337,189
Debt issuance costs, net	-	(0)
Net cash used by financing activites	(229,706)	205,039
Net increase (decrease) in cash and cash equivalents	(1,119,440)	284,967
Cash and cash equivalents, beginning of year	13,442,284	12,271,684
Cash and cash equivalents, end of year	12,322,844	12,556,651

MONADNOCK COMMUNITY HOSPITAL

STATISTICAL REPORT

January 31, 2020

Color Key:

Favorable variance > = +/-3%

Unfavorable variance > = +/-3%

	CURRENT MONTH					YEAR TO DATE				
	FY20 Act (2019-2020)	FY19 Act (2018-2019)	FY20 BUDGET	Act 20 vs Bud 20(+-)	Act 20 vs Act 19(+-)	FY20 Act (2019-2020)	FY19 Act (2018-2019)	FY20 BUDGET	Act 20 vs Bud 20(+-)	Act 20 vs Act 19(+-)
Inpatient										
Discharges (Excl. Newborn)	113	113	115	-2%	0%	494	432	458	8%	14%
Patient Days (Excl. Newborns)	428	373	411	4%	15%	1,640	1,457	1,643	0%	13%
Average Length of Stay	3.79	3.30	3.57	6%	15%	3.32	3.37	3.59	-7%	-2%
Case Mix Index	0.89	1.10	N/A	N/A	-18%	1.00	1.01	N/A	N/A	-1%
Occupancy	55%	48%	53%	4%	15%	53%	47%	53%	0%	13%
Average Daily Census	14	12	13	4%	15%	13	12	13	0%	13%
Outpatient (incl. Inpatient)										
Endo Cases	116	122	125	-7%	-5%	459	474	482	-5%	-3%
OR Cases	105	105	134	-22%	0%	427	466	521	-18%	-8%
ER Visits	1,231	1,157	1,232	0%	6%	4,562	4,580	4,771	-4%	0%
Imaging Services	2,711	2,889	2,887	-6%	-6%	10,640	11,132	11,166	-5%	-4%
Physical Rehabilitation	5,252	4,688	4,416	19%	12%	18,236	17,924	17,115	7%	2%
Lab	17,742	17,229	17,104	4%	3%	66,066	66,406	66,291	0%	-1%
Pharmacy	13,038	12,175	12,077	8%	7%	50,742	47,552	47,475	7%	7%
Physician Practices (WRVU's)										
Internal Medicine	1,650	1,545	1,480	12%	7%	6,325	5,609	5,845	8%	13%
Family Practice	5,270	5,008	5,088	4%	5%	19,214	18,235	20,200	-5%	5%
Pediatrics	2,611	2,320	2,468	6%	13%	9,767	8,868	9,539	2%	10%
Total Primary Care	9,531	8,873	9,036	5%	7%	35,307	32,712	35,584	-1%	8%
Behavioral Health	1,324	1,173	766	73%	13%	4,481	3,850	3,501	28%	16%
General Surgery	385	122	522	-26%	216%	1,915	593	2,016	-5%	223%
Orthopaedics	1,301	1,481	1,387	-6%	-12%	5,107	5,399	5,361	-5%	-5%
Physiatry	1,261	1,018	993	27%	24%	4,850	4,091	3,837	26%	19%
Other	245	256	221	11%	-4%	774	1,067	854	-9%	-28%
Total Specialists	4,515	4,050	3,889	16%	11%	17,125	15,000	15,569	10%	14%
Total WRVU's	14,047	12,923	12,925	9%	9%	52,432	47,712	51,153	3%	10%
Staffing										
Hospital FTE's	496	518	517	-4%	-4%	490	521	516	-5%	-6%
Outside Service FTE's	33	30	24	41%	10%	28	25	24	18%	10%

MONADNOCK COMMUNITY HOSPITAL
FINANCIAL SCORECARD
FISCAL 2020

Color Key:
Green - Favorable Measure or No Concerns
Red - Unfavorable Measure
Black - On Target
XXXXX - N/A

Category	FY 2019	2020 Objective	Q1 YTD	Q2 YTD	S&P Median Small Hospitals BBB-	BBB	A	Reporting Definition
Net Operating Revenues	90,785,671	95,167,974	24.2%	32.7%				% of Objective
Operating Income	(755,386)	453,511	20.0%	43.9%				% of Objective
Operating EBIDA	4,745,017	6,106,508	23.6%	32.7%				% of Objective
Net Income	(574,339)	920,757	57.9%	72.0%				% of Objective
PROFITABILITY								
Operating Margin	-0.8%	0.5%	0.4%	0.6%	-2.5%	1.6%	4.5%	YTD %
Operating EBIDA Margin	5.2%	6.4%	6.3%	6.4%	6.5%	8.9%	11.1%	YTD %
Excess Margin	-0.6%	1.0%	2.3%	2.1%	-1.2%	5.3%	8.3%	YTD %
DEBT POSITION								
Annual Debt Service Coverage (x) [1]	2.8	5.5	4.2	4.1	1.6	4.0	4.0	YTD Actual
Debt Service / Op. Revenues	1.9%	1.9%	1.9%	1.9%				YTD Actual
Long Term Debt to Capitalization [2]	26.8%	26.6%	25.8%	25.6%	32.9%	22.3%	15.1%	YTD Actual
Cash Flow / Total Liabilities	19.5%	20.1%	20.8%	12.1%	11.1%	10.1%	32.4%	
LIQUIDITY								
Cash to Debt	302.8%	302.5%	314.9%	315.5%	165.1%	251.8%	300.9%	YTD Actual
Cash on Hand (days) [3]	308.78	298.8	320.8	317.4	179	247	368	YTD Actual
Days in A/R (net)	37.5	32.4	33.4	36.4	49.4	49	48.6	YTD Actual
Days in A/P (net)	33.6	32.5	32.0	30.3				YTD Actual
Current Ratio	0.5	0.5	0.5	0.4				YTD Actual
OTHER RATIOS & INFORMATION								
Bad Debt to Gross Revenues	3.0%	3.0%	2.8%	2.7%				YTD Actual
Compensation Ratio	51.1%	50.5%	50.4%	50.1%				YTD Actual
Contractual Adjustments %	46.6%	47.6%	48.0%	47.0%				YTD Actual
Policy Discounts %	1.4%	1.2%	1.0%	1.1%				YTD Actual
Charity Care %	1.1%	1.1%	0.9%	1.0%				YTD Actual
Total Deduction %	49.5%	50.4%	49.8%	49.6%				YTD Actual
Collection Rate	50.5%	49.6%	50.2%	50.4%				YTD Actual
Average Age of Plant	14.0	14.6	15.3	15.3	11.3	12.7	13.6	YTD Actual

Payor Mix	Inpatient FY 2020 Actual	Inpatient FY 2020 Budget	Inpatient FY 2019 YTD 9/30	Outpatient FY 2020 Actual	Outpatient FY 2020 Budget	Outpatient FY 2019 YTD 9/30
Anthem	13.0%	12.1%	12.2%	12.5%	13.3%	13.1%
CIGNA	5.1%	4.8%	4.6%	7.6%	7.1%	7.2%
Commercial	8.4%	10.7%	11.2%	12.8%	13.6%	13.5%
HPHC	4.3%	3.1%	3.3%	6.3%	6.5%	6.5%
Medicaid	13.3%	10.0%	10.0%	8.7%	8.0%	8.0%
Medicare	53.8%	56.5%	55.5%	48.2%	47.8%	47.7%
Private	2.1%	2.8%	3.2%	3.9%	3.8%	4.0%

Staffing Complement: Total Hospital Productivity (including OOS)*		
Actual	HT Target	Hospital Target
379.76	354.68	398.34

[1] 2013 Bond covenants require a minimum of 1.5x to 1.0x.

[2] 2013 Bond covenants require a maximum of 60%.

[3] 2013 Bond covenants require a minimum of 75 days.

Monadnock Community Hospital
Financial Scorecard Definitions

Financial Indicators	Calculation	Purpose
Operating Income	Net Operating Revenue - Total Operating Expense	Otherwise known as Gain(Loss) from Patient Care, this measures the amount of profit generated from operations after all expenses are paid.
Operating EBIDA	Gain(Loss) from Patient Care + Interest + Depreciation	Indicates profitability without the affect of Interest and Depreciation.
Net Income	Gain(Loss) from Patient Care + Non-Operating Revenues and Expenses	Measures overall profitability.

Profitability Ratios	Calculation	Purpose
Operating margin	Gain/(Loss) from patient care / Net Operating Revenue	Measures profit retained per dollar of revenue.
Operating EBIDA margin	Operating EBIDA / Net Operating Revenue	Expression of EBIDA (used to value the organization, regardless of capital structure) as a percentage of total revenue.
Excess margin	Gain/(Loss) after Non Op Rev / Net Operating Revenue	Helps monitor the level of profit being generated.

Debt Position Ratios	Calculation	Purpose
Annual Debt Service Coverage	(Net Income + Depreciation + Interest) / (Current portion of long-term debt + Current portion of capital lease obligations prorated + Interest)	Indicates how many times the organization's debt service requirements could be met from annual cash flow.
Debt Service / Operating Revenues	(Current portion of long-term debt + Current portion of capital lease obligations prorated + Interest) / Net Operating Revenue	To express total debt and interest as a percentage of Net Operating Revenue.
Long-Term debt to capitalization	(Long Term Debt * 100) / (Unrestricted Net Assets + Long Term Debt)	Measures the amount of capital financed via debt.
Cash Flow / Total Liabilities	Annualized Cash Flow / Total Liabilities	Indicates the ability to cover total debt with yearly cash flow from operations.

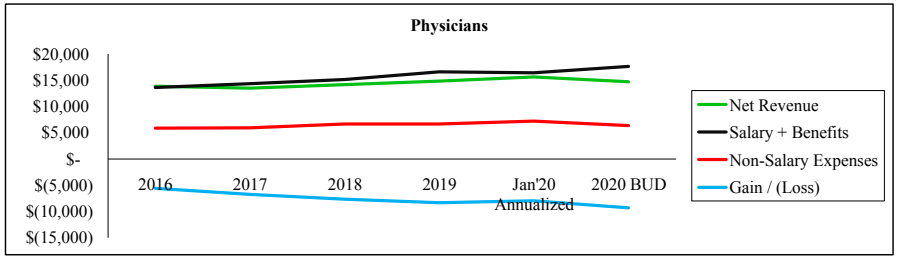
Liquidity Ratios	Calculation	Purpose
Cash to Debt	Unrestricted Cash / (Long Term Debt + Short Term Debt)	Indicates the ability to cover total debt.
Cash on Hand (days)	(Cash + Unrestricted Investments) / ((Total Op Exp - Depreciation Exp) / # Days in Period)	Measures the amount of cash available to meet operating expenses.
Net Days in A/R	Net Accounts Receivable / (Net Patient Revenue / Days in the Period)	Measures turn around time for cash collections.
Net Days in A/P	(Accounts Payable + Accrued Salaries) / (Total Operating Expenses / Days in the Period)	Measures turn around time for cash payments.
Current Ratio	Current Assets / Current Liabilities	Indicates the ability to pay short-term debt obligations with short-term assets. Measures the efficiency of a company's operating cycle or its ability to turn product into cash.

Other Ratios & Information	Calculation	Purpose
Bad Debt to Gross Revenues	Bad Debt Expense / Gross Revenues	To express Bad Debt as a percentage of Gross Revenue.
Compensation Ratio	(Salaries Expense + Benefits Expense) / Net Operating Revenue	To express Staffing expense as a percentage of Net Operating Revenue.
Contractual Adjustments %	Contractual Adjustment / Gross Revenue	To express Contractual Adjustments as a percentage of Gross Revenue.
Policy Discounts %	Policy Discount / Gross Revenue	To express Policy Discounts as a percentage of Gross Revenue.
Charity Care %	Charity Care / Gross Revenue	To express Charity Care as a percentage of Gross Revenue.
Total Deduction %	Total Revenue Deductions / Gross Revenue	To express Total Revenue Deductions as a percentage of Gross Revenue.
Collection Rate	(1 - Total Deduction %)	To express the rate of cash collections after all Revenue Deductions.
Average age of plant	Accumulated Depreciation / Depreciation Expense	The financial age of the fixed assets of the hospital. The older the average age, the greater the short term need for capital resources.

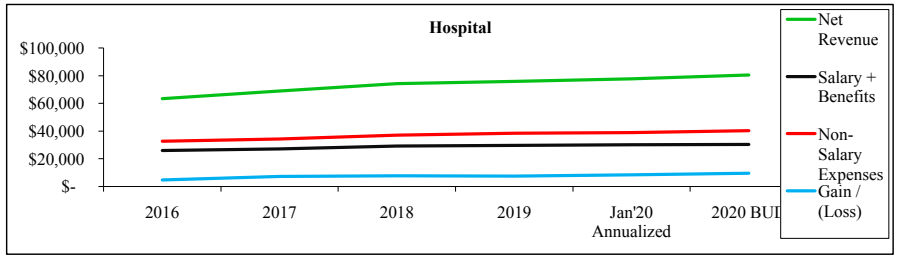
MONADNOCK COMMUNITY HOSPITAL
PROVIDER AND HOSPITAL P&L ANALYSIS
2016 Actuals - 2020 Actuals

Results in (000's)

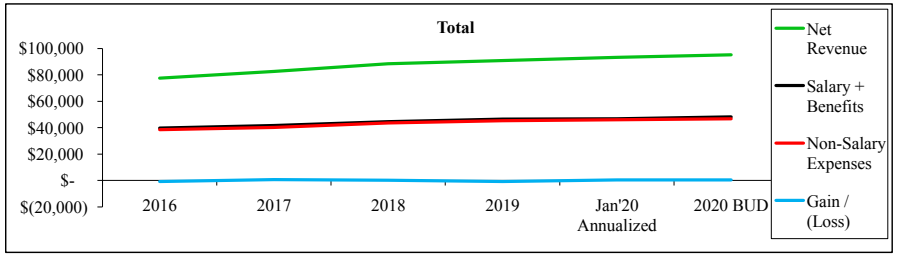
	2016	2017	2018	2019	Jan'20 Annualized	Jan'20 YTD	2020 BUD
Net Revenue	$ 13,859	$ 13,496	$ 14,157	$ 14,863	$ 15,635	$ 5,212	$ 14,718
Salary + Benefits	13,591	14,322	15,162	16,608	16,418	5,473	17,673
Non-Salary Expenses	5,856	5,917	6,665	6,618	7,191	2,397	6,361
Total Expenses	19,448	20,239	21,827	23,226	23,609	7,870	24,034
Gain / (Loss)	**$ (5,588)**	**$ (6,743)**	**$ (7,671)**	**$ (8,363)**	**$ (7,974)**	**$ (2,658)**	**$ (9,316)**



	2016	2017	2018	2019	Jan'20 Annualized	Jan'20 YTD	2020 BUD
Net Revenue	$ 63,531	$ 69,025	$ 74,179	$ 75,923	$ 77,637	$ 25,879	$ 80,450
Salary + Benefits	25,993	27,233	29,236	29,804	30,267	10,089	30,406
Non-Salary Expenses	32,648	34,299	36,942	38,511	38,798	12,933	40,275
Total Expenses	58,642	61,532	66,178	68,315	69,065	23,022	70,681
Gain / (Loss)	**$ 4,889**	**$ 7,493**	**$ 8,000**	**$ 7,608**	**$ 8,572**	**$ 2,857**	**$ 9,769**



	2016	2017	2018	2019	Jan'20 Annualized	Jan'20 YTD	2020 BUD
Net Revenue	$ 77,390	$ 82,521	$ 88,335	$ 90,786	$ 93,272	$ 31,091	$ 95,168
Salary + Benefits	39,585	41,556	44,399	46,412	46,685	15,562	48,079
Non-Salary Expenses	38,504	40,215	43,607	45,129	45,989	15,330	46,635
Total Expenses	78,089	81,771	88,006	91,541	92,674	30,891	94,714
Gain / (Loss)	**$ (699)**	**$ 750**	**$ 330**	**$ (755)**	**$ 598**	**$ 199**	**$ 454**



Notes:
* Expenses reflect direct costs, not fully allocated costs.

Source:
- Webstations for Execs Roll-up 502.

Executive Summary

The purpose of this document is to provide a draft overview of the month-end results for the period ending December 31, 2019 compared to the budget for Huggins Hospital. This summary should be read in conjunction with the financial statements contained in the package.

The total operating loss for the month was ($552k), which was less than budget by $100k and worse than the prior year gain for the same period by ($675k). Year-to-date, Huggins remains ahead of the budget with a current operating loss of ($449k) compared to a budgeted loss of ($937k) which is $488k better than anticipated but ($25k) less than prior year at this same time. Revenues for December were $1.67M greater than budgeted expectations primarily driven by outpatient revenue being above budget by approximately $1M. Year to date, gross charges are $3.9M or 13% better than anticipated and $5.0M or 17% better than prior year. These gains YTD have been partially offset by changes in contractual allowances.

Operating expenses are running high compared to budget and greater than the prior year at this time. For the month of December, operating expenses were ($186k) or 3% over budget. This overage is related to supply costs, which are approximately $100k over budget and $85k higher than prior year at this time (attributed to drug purchases). Net patient service revenue was approximately $100k higher than anticipated during the month of December. A further breakdown of expenses and other operating revenue is included in the Operational highlights below.

December exceeded budgeted expectations on the non-operating side. Unrealized investment activity significantly exceeded budget.

Operational Highlights

Revenues:

- In December, Gross Patient Service Revenues were approximately $11.372M. This was $1.674M higher than budget for the month. Inpatient revenue was $399k or 24% higher than budget for the month. Outpatient Revenue was $996k or 15% higher than budgeted expectations for the month. Physician Practice Revenue was $278k or 18% higher than budgeted expectations for the month.

- The $399k better than budgeted results in Inpatient Revenue was driven by:
    - OR is $417k above budget
    - ICU is $22k above budget
    - Pharmacy is $27k above budget

- The $996k higher than budgeted results in Outpatient Revenue was driven by:
    - Med Surg $92k over budget
    - Operating room is $48k over budget
    - Emergency department is $227k over budget
    - Radiology – Nuclear Medicine is $73k over budget
    - Radiology – CT Scan is $190k above budget
    - Note: Pharmacy is below the budget by $317k

- The $278k higher than budgeted results in Physician Practice Revenue was drive by:
    - Orthopedics is $193k above budget
    - Wolfeboro General Surgery is $64k above budget
    - Wolfeboro Family Med is $100k above budget

- Other revenue was $376k and under budget by ($16k).

Revenue Deductions:

- Overall Revenue Deductions were $6.5M in December, which was $1.57M higher than budget.
- The contractual allowances year to date were 21% or $3.29M higher than budget.

Expenses:

- Overall operating expenses were $5.83M for the month. This was ($186k) higher than budget
- YTD expenses of $17.0M compared to $16.9M budgeted. This is ($152k) higher than budget.

    - **Salaries and Wages**: Expenses were $2.628M compared to a budget of $2.637M. This was $9k better than budget. YTD expenses of $7.992M compared to a budget of $7.897M.
    - **Benefits**: Expenses were $644k compared to a budget of $556k. YTD expenses of $1.7M compared to a budget of $1.69M. This is ($63k) higher than budget.
        - The monthly benefits were over budget as a result of our last Anthem billing. We will begin to account for the self-insured plan beginning in February.
    - **Physician Fees**: Expenses were $315k compared to a budget of $287k or ($27k) higher than budget. YTD expenses of $879k compared to a budget of $863k. This is ($16k) or 2% higher than budget.
        - Departments that are the primary drivers of these fees: Anesthesiology, Emergency Room Physicians, Hospitalists, and Wolfeboro General Surgery.
    - **Other Expenses:** Expenses in December were $948k compared to a budget of $942k. YTD expenses of $2.623M compared to a budget of $2.828M. A total of $205k under budget.
        - Most accounts within Other Expenses were in line with budget. Contractual services was approximately $90k over budget.
        - In general a significant amount of invoices were accrued for in December – approximately $300k. This typically occurs during the month of December as vendors are trying to collect on all outstanding invoices for their calendar year end.
        - Built into the other expenses YTD budget line is the anticipated cost of increased operational expenses from the Acute Go Live date in March. We expect to see months in excess of the budget once these costs begin to be incurred.
    - **Interest Expense**: For the current month, interest expense is approximately $22k under budget and $68k under budget YTD. Built into the interest expense budget line is the anticipated cost of a draw down from the line of credit, thus the current favorable variance.

<u>Non-Operational Highlights</u>

Investment Income:

- Total non-operating income for the month was $1.1M. This was $1.085M better than budget. Unrealized gains were significant for almost all investment accounts.

Increase in Unrestricted Net Assets:

The total increase in Unrestricted Net Assets for the month was $555k. This was $985k better than budget.

Financial Statements
December 31, 2019

Huggins Hospital
Balance Sheet
December 31, 2019

	Current Year	Fiscal Y/E Prior Year	Net Change
Assets			
Current Assets			
Cash and Cash Equivalents	12,554,007	10,615,033	1,938,973
Patient Accounts Receivable, Net	7,980,323	8,802,983	(822,660)
Inventories	568,210	573,385	(5,176)
Prepaid/Other Current Assets	1,588,556	2,003,453	(414,897)
Intercompany Receivable	700,000	700,000	-
Total Current Assets	**23,391,095**	**22,694,854**	**696,241**
Assets Limited to Use	65,469,559	63,160,664	2,308,894
Property and Equipment:			
Property and Equipment	94,139,241	92,482,421	1,656,820
Accumulated Depreciation	(47,981,895)	(46,900,120)	(1,081,775)
Property and Equipment, Net	46,157,347	45,582,302	575,045
Total Assets	**135,018,000**	**131,437,820**	**3,580,179**

	Current Year	Fiscal Y/E Prior Year	Net Change
Liabilities and Net Assets			
Current Liabilities			
Current Portion - Long Term Debt	623,694	618,470	5,224
Accounts Payable and Accrued Expenses	4,428,203	4,611,303	(183,100)
Accrued Salaries, Wages and Benefits	3,174,549	2,386,134	788,415
Estimated Third Party Settlements	24,756,120	23,856,120	900,000
Amounts Due to Affiliates	60,545	30,545	30,000
Total Current Liabilities	**33,043,110**	**31,502,571**	1,540,539
Accrued Pension and Other Long Term Liabilities	2,857,862	3,193,584	(335,722)
Long Term Debt, Net of Current Portion	19,404,044	19,514,216	(110,172)
Total Liabilities	**55,305,016**	**54,210,371**	**1,094,645**
Unrestricted	60,463,666	58,262,453	2,201,213
Temporarily Restricted	9,685,619	9,099,540	586,079
Permanently Restricted	9,563,699	9,865,457	(301,758)
Total Net Assets	**79,712,984**	**77,227,449**	**2,485,534**
Total Liabilities & Net Assets	**135,018,000**	**131,437,820**	**3,580,178**

Huggins Hospital
Statement of Operations
December 31, 2019

	Month					Year to Date				Prior Year to Date		
	Actual	Budget	Variance	%	PY Actual	Actual	Budget	Variance	%	Actual	Variance	%
Gross Patient Service Revenue												
Inpatient	2,059,210	1,659,896	399,313	24%	1,745,755	5,415,686	5,026,026	389,660	8%	4,898,665	517,021	11%
Outpatient	7,505,761	6,509,186	996,575	15%	6,401,758	23,389,113	20,385,290	3,003,822	15%	19,613,769	3,775,344	19%
Physician Practice Revenue	1,806,595	1,528,504	278,091	18%	1,408,043	5,552,416	5,025,813	526,603	10%	4,810,908	741,508	15%
Gross Patient Service Revenue	**11,371,566**	**9,697,586**	**1,673,980**	**17%**	**9,555,555**	**34,357,215**	**30,437,129**	**3,920,086**	**13%**	**29,323,342**	**5,033,873**	**17%**
Contractual Allowances												
Contractual Allowances	6,176,632	4,741,623	(1,435,009)	-30%	4,844,192	17,828,545	15,090,644	(2,737,901)	-18%	15,019,601	(2,808,944)	-19%
DSH Funding	(208,333)	(250,000)	(41,667)	-17%	(250,000)	(558,725)	(750,000)	(191,275)	-26%	(812,500)	(253,775)	-31%
Charity Care Allowances	53,451	113,256	59,804	53%	31,701	188,572	360,447	171,875	48%	369,362	180,790	49%
Bad Debt Allowances	451,199	296,136	(155,064)	-52%	384,535	1,471,363	942,479	(528,884)	-56%	900,452	(570,911)	-63%
	6,472,949	**4,901,014**	**(1,571,935)**	**-32%**	**5,010,428**	**18,929,754**	**15,643,570**	**(3,286,184)**	**-21%**	**15,476,915**	**(3,452,839)**	**-22%**
Net Patient Service Revenue	**4,898,617**	**4,796,572**	**102,045**	**2%**	**4,545,127**	**15,427,461**	**14,793,560**	**633,901**	**4%**	**13,846,427**	**1,581,034**	**11%**
Other Operating Revenue	376,071	392,189	(16,118)	-4%	635,846	1,184,312	1,176,567	7,744	1%	1,282,612	(98,301)	-8%
Total Operating Revenue	**5,274,688**	**5,188,761**	**85,927**	**2%**	**5,180,973**	**16,611,772**	**15,970,127**	**641,645**	**4%**	**15,129,039**	**1,482,733**	**10%**
Expenses												
Salaries & Wages	2,628,833	2,637,858	9,024	0%	2,298,538	7,992,127	7,897,712	(94,415)	-1%	7,285,796	(706,331)	-10%
Benefits	644,992	556,334	(88,659)	-16%	544,427	1,732,120	1,669,001	(63,119)	-4%	1,625,821	(106,298)	-7%
Supplies	577,259	466,074	(111,185)	-24%	485,602	1,724,936	1,398,223	(326,713)	-23%	1,302,707	(422,229)	-32%
Physician Fees	315,499	287,805	(27,694)	-10%	257,304	879,946	863,414	(16,532)	-2%	758,610	(121,336)	-16%
Other	959,228	942,974	(16,254)	-2%	775,866	2,628,370	2,828,922	200,553	7%	2,537,202	(91,168)	-4%
MET	207,846	207,846	0	0%	225,266	623,539	623,539	0	0%	613,298	(10,241)	-2%
Depreciation	411,144	437,500	26,356	6%	380,833	1,233,431	1,312,500	79,069	6%	1,142,499	(90,933)	-8%
Interest	82,460	104,792	22,332	21%	89,785	246,084	314,376	68,293	22%	286,480	40,396	14%
Total Expenses	**5,827,262**	**5,641,183**	**(186,079)**	**-3%**	**5,057,619**	**17,060,552**	**16,907,688**	**(152,865)**	**-1%**	**15,552,412**	**(1,508,140)**	**-10%**
Operating Gain/(Loss)	**(552,574)**	**(452,422)**	**(100,152)**	**-22%**	**123,353**	**(448,780)**	**(937,561)**	**488,781**	**52%**	**(423,372)**	**(25,408)**	**-6%**
Non Operating Income	1,107,853	22,500	1,085,353	4824%	(2,029,100)	2,649,993	67,500	2,582,493	3826%	(3,943,344)	6,593,337	-167%
Increase/Decrease in Net Assets	**555,279**	**(429,922)**	**985,200**	**229%**	**(1,905,746)**	**2,201,213**	**(870,061)**	**3,071,274**	**353%**	**(4,366,716)**	**6,567,929**	**150%**
Stats:												
Allowances as a % of Gross	54%	49%	5%		51%	52%	50%	2%		51%	1%	
Charity as a % of Gross	0%	1%	-1%		0%	1%	1%	-1%		1%	-1%	
Bad Debt as a % of Gross	4%	3%	1%		4%	4%	3%	1%		3%	1%	
Payment %	43%	49%	-6%		48%	45%	49%	-4%		47%	-2%	
Salary&Benefits as % of NPSR	67%	67%	0%		63%	63%	65%	-2%		64%	-1%	
Benefits as % of Salary	25%	21%	3%		24%	22%	21%	1%		22%	-1%	
Operating Margin %	-10%	-9%	-2%		2%	-3%	-6%	3%		-3%	0%	
EBITDA %	-1%	2%	-3%		11%	6%	4%	2%		7%	0%	

Huggins Hospital
Cash Flow Statement
December 31, 2019

			12/31/2019	Fiscal Year to Date
Balance as Beginning of Period			**11,612,245**	**10,615,033**
Cash from Operations				
	Cash Receipts			
		Cash from Patients & Insurance	5,282,373	16,404,482
		DSH	-	-
		Contributions- General	27,059	137,413
		Other/Cost Report Settlement	-	-
	Cash Paid			
		Payroll & Payroll Taxes	(2,194,846)	(6,382,145)
		General Expenses	(1,186,836)	(6,238,457)
		MET Payment	-	-
Net Cash Flow from Operations			**1,927,750**	**3,921,293**

			12/31/2019	Fiscal Year to Date
Cash from Investing Activities				
	Cash Receipts			
		Transfers from Investments	47,000	141,000
	Cash Paid			
		Purchase of Property & Equipment	(928,041)	(1,808,476)
	Net Cash from Investing Activities		**(881,041)**	**(1,667,476)**
Cash from Financing Activities				
	Cash Paid			
		Bond Debt	(104,948)	(314,844)
	Net Cash from Financing Activities		**(104,948)**	**(314,844)**
Net Increase (Decrease) in Cash			**941,761**	**1,938,972**
Ending Cash Balance			**12,554,007**	**12,554,007**

Huggins Hospital
Accounts Receivable (000's Omitted)
December 31, 2019

AGED ACCOUNT RECEIVABLE

	Hospital	Practices	Total
0 - 30	7,471	721	8,192
31 - 60	2,545	197	2,742
61 - 90	1,368	184	1,552
91 - 120	965	115	1,080
Over 120	2,581	745	3,326
Total	**14,930**	**1,962**	**16,892**
0 - 30	50%	37%	48%
31 - 60	17%	10%	16%
61 - 90	9%	9%	9%
91 - 120	6%	6%	6%
Over 120	17%	38%	20%
Total	100%	100%	100%

GROSS AR DAYS

	Current	FY19	FY18	FY17
Hospital*	47.17	51.37	48.48	45.12
Physician Practice	33.48	31.96	28.95	23.02
Total - Gross	**44.96**	**43.67**	**41.89**	**36.76**

** Hospital AR is slightly overstated as some Physician Practice AR is in the hospital system but the revenue is not.*

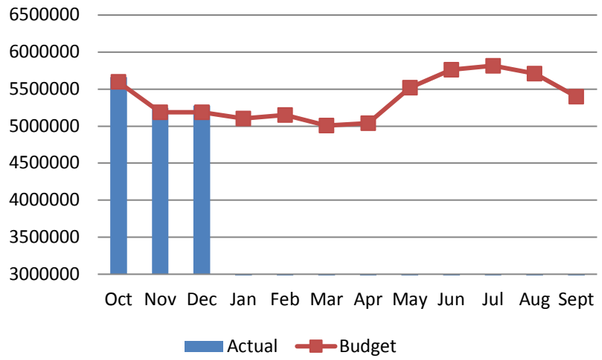
Huggins Hospital
FY 2020 Statistics
December 31, 2019

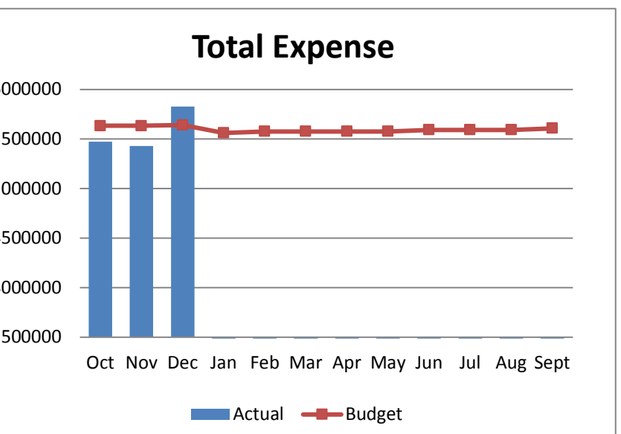
	Month				Year to Date				Prior Year to Date		
	Actual	Budget	Variance	%	Actual	Budget	Variance	%	Actual	Variance	%
Patient Days											
ICU	42	28	14	50%	112	91	21	23%	90	22	24%
Med/Surg	180	140	40	29%	480	444	36	8%	438	42	10%
Swing	101	152	(51)	-34%	246	465	(219)	-47%	511	(265)	-52%
Discharges											
Acute	63	47	16	34%	177	160	17	11%	154	23	15%
Swing	14	13	1	8%	34	45	(11)	-24%	44	(10)	-23%
LOS											
Acute	3.5	3.6	(0.1)	-1%	3.3	3.3	0.0	0%	3.4	(0.1)	-2%
Swing	7.2	11.7	(4.5)	-38%	7.2	10.3	(3.1)	-30%	11.6	(4.4)	-38%
Adjusted Patient Days	1,784	1,870	(86)	-5%	5,316	6,056	(740)	-12%	6,219	(903)	-15%
Observation Patients	38	28	10	36%	107	80	27	34%	80	27	34%
Observation Hours	1,580	870	710	82%	4,622	3,235	1,387	43%	3,619	1,003	28%
Surgical Services											
Inpatients	11	12	(1)	-8%	33	32	1	3%	22	11	50%
Outpatients	125	105	20	19%	375	327	48	15%	323	52	16%
Imaging Services											
X-Ray	1,116	1,036	80	8%	3,527	3,345	182	5%	3,337	190	6%
Ultrasound	239	223	16	7%	790	750	40	5%	758	32	4%
Nuclear Med	42	20	22	110%	123	70	53	76%	74	49	66%
CT Scan	373	269	104	39%	1,139	915	224	24%	918	221	24%
MRI	55	87	(32)	-37%	247	252	(5)	-2%	262	(15)	-6%
Laboratory Tests	13,796	14,126	(330)	-2%	45,386	45,424	(38)	0%	46,449	(1,063)	-2%
Rehabilitation Services											
PT Evals/Re evals	223	186	37	20%	704	600	104	17%	611	93	15%
PT Billable Units	4,183	3,851	332	9%	14,420	12,140	2,280	19%	12,551	1,869	15%
OT Evals/Re evals	49	47	2	4%	144	151	(7)	-5%	142	2	1%
OT Billable Units	439	597	(158)	-26%	1,709	2,112	(403)	-19%	2,211	(502)	-23%
ST Evals/Re evals	12	6	6	100%	36	16	20	125%	30	6	20%
ST Billable Units	42	24	18	75%	139	83	56	67%	81	58	72%

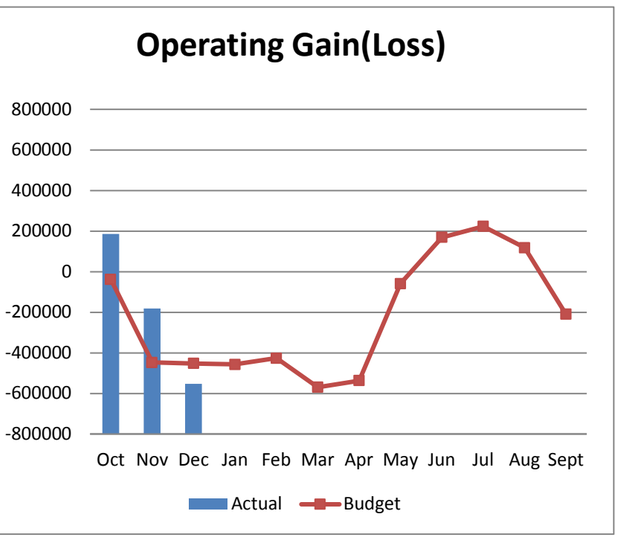
Huggins Hospital
FY 2020 Statistics
December 31, 2019

	Month				Year to Date				Prior Year to Date		
	Actual	Budget	Variance	%	Actual	Budget	Variance	%	Actual	Variance	%
Respiratory	158	93	65	70%	355	344	11	3%	170	185	109%
EKG	306	261	45	17%	960	869	91	10%	847	113	13%
Stress Test	39	28	11	39%	128	102	26	25%	89	39	44%
Cardiac Rehab	123	168	(45)	-27%	347	418	(71)	-17%	438	(91)	-21%
ED Visits	808	721	87	12%	2,495	2,261	234	10%	2,262	233	10%
Physician Practices											
Alton	841	816	25	3%	2,506	2,993	(487)	-16%	2,432	74	3%
Moultonborough	682	579	103	18%	2,458	2,205	253	11%	2,179	279	13%
Ossipee	304	454	(150)	-33%	1,175	1,636	(461)	-28%	1,324	(149)	-11%
Tamworth	787	672	115	17%	2,304	2,131	173	8%	2,088	216	10%
Wolfeboro	798	937	(139)	-15%	2,934	2,570	364	14%	2,531	403	16%
Pediatrics	541	624	(83)	-13%	2,055	1,989	66	3%	1,951	104	5%
IMOW	427	895	(468)	-52%	2,485	2,577	(92)	-4%	2,076	409	20%
Subtotal FP/Peds	**4,380**	**4,977**	**(597)**	**-12%**	**15,917**	**16,101**	**(184)**	**-1%**	**14,581**	**1,336**	**9%**
Orthopedics	746	324	422	130%	1,573	1,080	493	46%	1,267	306	24%
Surgical	338	147	191	130%	770	606	164	27%	608	162	27%
Women's Health	90	68	22	32%	331	301	30	10%	382	(51)	-13%
Hospitalist	281	261	20	8%	862	854	8	1%	787	75	10%
Total All Practices	**5,835**	**5,777**	58	**1%**	**19,453**	**18,942**	511	**3%**	**17,625**	**1,828**	**10%**
FTE's											
Productive	354				353				347	6	2%
Non Productive	47				46				33	13	39%
OT	9				9				8	1	13%
Total	**410**				**408**				**388**	**20**	**5%**

Financial Dashboard - FY 2019







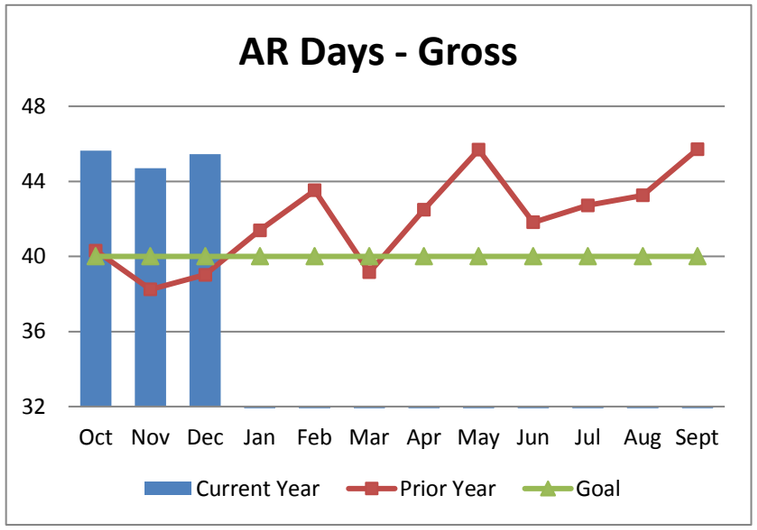
Income Statement	O	N	D	J	F	M	A	M	J	J	A	S	YTD	Budget
Operating Margin % (>Budget)	3%	-3%	-10%										-3%	1%
EBITDA % (>Budget)	12%	6%	-1%										6%	10%
Personnel Cost % (<Budget)	57%	60%	62%										60%	62%

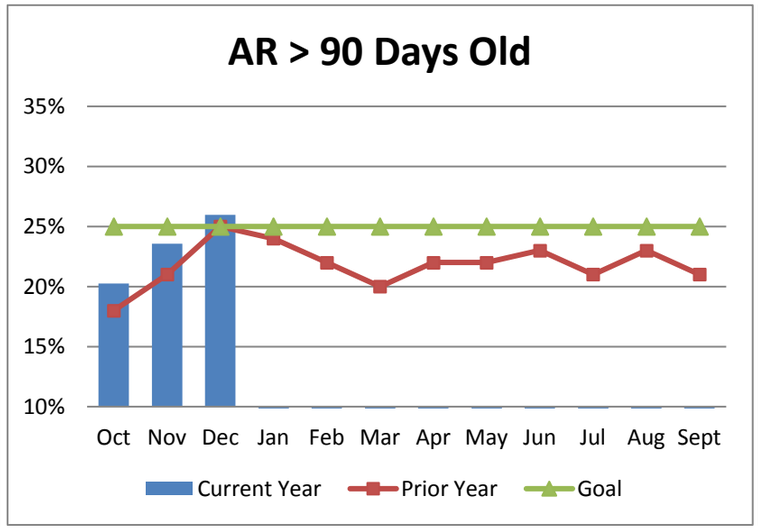
Balance Sheet	O	N	D	J	F	M	A	M	J	J	A	S
Cash Balance (millions)	11.8	11.4	12.5									
Short-term Days Cash (>30)	70.1	70.4	76.0									
Investments+ALATU (millions)	55.8	56.6	58.5									
Current Ratio (>1.5)	0.7	0.7	0.7									
3rd Party Settlements (millions)	24.0	24.1	24.8									

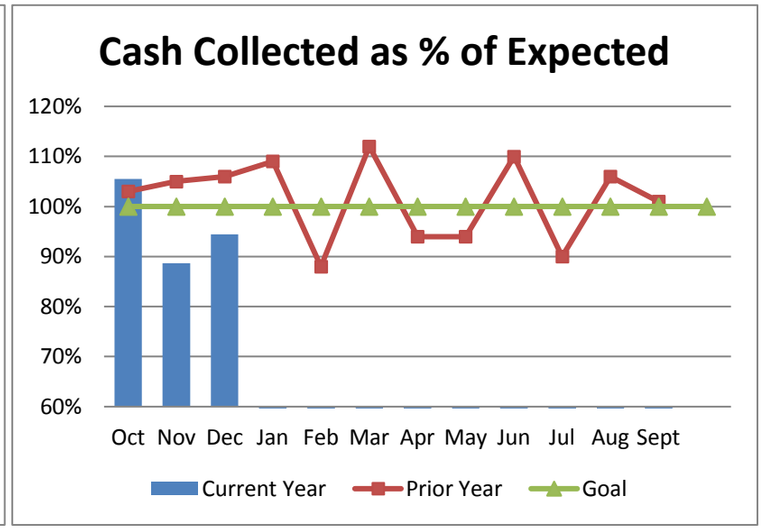
Bond Covenants (YTD)	O	N	D	J	F	M	A	M	J	J	A	S
Days Cash on Hand (>100)	336	338	346									
Debt to Capitalization (<0.55)	0.25	0.25	0.24									
Debt Service Coverage (>1.25)	4.92	5.68	5.34									

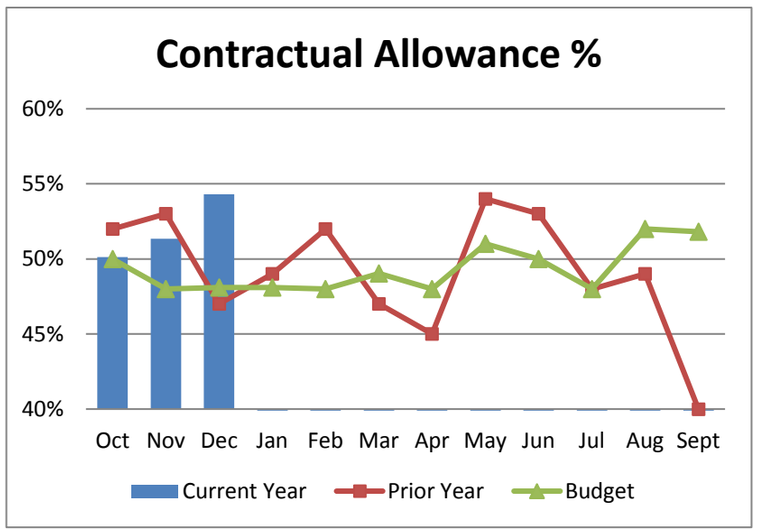
Volumes	O	N	D	J	F	M	A	M	J	J	A	S	YTD
ICU Days (>35)	38	32	42										112
Med/Surg Days (>166)	168	132	180										480
Swing Days (>127)	66	79	101										246
Acute LOS Days (<4)	3.27	3.22	3.52										3.34
Observation Hours (>1,083)	1,580	1,462	1,580										4,622
Inpatient Surgical Patients (>17)	13	9	13										35
Day Surgery Patients (>121)	117	133	117										367
Radiology Exams (>1,980)	2,189	1,812	1,825										5,826
Laboratory Tests (>13,264)	16,934	14,656	13,796										45,386
Rehab Units (>4,971)	6,801	5,403	4,948										17,152
Emergency Room Visits (>834)	946	741	808										2,495
Physician Practice Visits (>5,574)	6,897	6,721	5,835										19,453

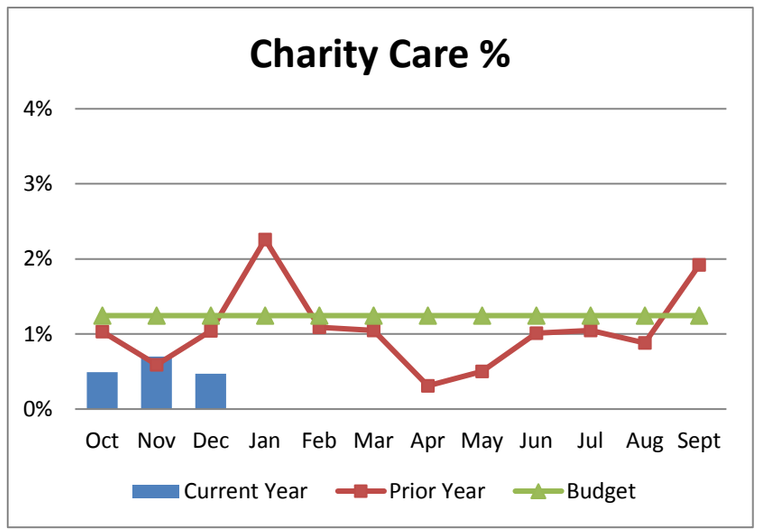
Financial Dashboard - FY 2019

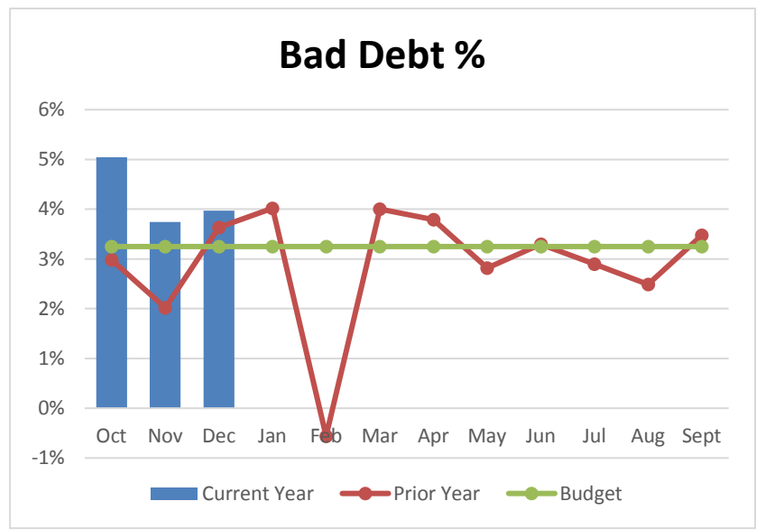












Payor Mix	O	N	D	J	F	M	A	M	J	J	A	S	YTD	PY	VAR
Medicare	48%	48%	47%										**48%**	49%	-1%
Medicaid	12%	12%	13%										**12%**	10%	2%
Commercial	36%	36%	36%										**36%**	36%	0%
Private Pay	4%	4%	4%										**4%**	5%	-1%

Other Measures	O	N	D	J	F	M	A	M	J	J	A	S	YTD
Cost to Collect % (<3%)	4.7%	2.9%	2.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.6%

Attachment 4

D-HH Financial Results for Quarter Ended 12/31/19

Dartmouth-Hitchcock Health and Subsidiaries

Consolidated Financial Statements and Supporting Exhibits

For the Six Months Ended December 31, 2019

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Statement of Operations
For the period ended December 31, 2019
($ in 000s)

Current Quarter				Year-to-Date		
Actual	**Budget**	**Variance**		**Actual**	**Budget**	**Variance**
			Revenue and other support:			
$ 497,640	$ 502,950	(5,310)	Net patient service revenue	$ 992,547	$ 1,003,625	(11,078)
19,897	21,100	(1,203)	Contracted revenue	41,448	38,394	3,054
69,971	64,960	5,011	Other operating revenue	131,145	124,491	6,654
4,148	3,292	856	Net assets released from restrictions	7,273	6,380	893
591,656	592,302	(646)	Total revenue and other support	1,172,413	1,172,890	(477)
			Operating expenses:			
101,556	96,783	(4,773)	Physician salaries	200,919	193,004	(7,915)
184,681	187,324	2,643	Staff salaries	361,168	364,908	3,740
67,234	69,440	2,206	Employee benefits	136,703	138,045	1,342
116,019	104,623	(11,396)	Medical supplies and medications	221,824	205,396	(16,428)
89,307	87,964	(1,343)	Purchased services and other	172,052	172,911	859
18,958	18,996	38	Medicaid enhancement tax	37,915	37,969	54
30,236	30,930	694	Depreciation, amortization and interest	59,296	61,840	2,544
607,991	596,060	(11,931)	Total operating expenses	1,189,877	1,174,073	(15,804)
(16,335)	(3,758)	(12,577)	Operating margin before DSH	(17,464)	(1,183)	(16,281)
15,335	15,308	27	Medicaid Uncompensated Care Payment (DSH)	30,644	30,607	37
$ (1,000)	$ 11,550	(12,550)	**Operating (loss) margin**	$ 13,180	$ 29,424	(16,244)
-0.2%	1.9%		**Operating margin (%)**	1.1%	2.4%	

		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Actual	2020	$6,228	$4,376	$3,576	$8,710	($6,325)	($3,385)						
Budget	2020	$6,521	$7,046	$4,307	$10,540	($1,332)	$2,342	$3,220	$1,907	$5,978	$5,012	$5,461	$8,454
Actual	2019	$7,330	$13,416	$162	$13,034	$4,328	$4,431	$3,425	$3,310	($4,680)	$6,592	$7,353	$11,001

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Statement of Operations
For the period ended December 31, 2019 and 2018
($ in 000s)

Current Quarter				Year-to-Date		
December 2019	**December 2018**	**Variance**		**December 2019**	**December 2018**	**Variance**
			Rrevenue and other support:			
$ 497,640	$ 491,083	6,557	Net patient service revenue	$ 992,547	$ 960,657	31,890
19,897	17,829	2,068	Contracted revenue	41,448	35,381	6,067
69,971	51,068	18,903	Other operating revenue	131,145	93,929	37,216
4,148	3,638	510	Net assets released from restrictions	7,273	6,772	501
591,656	563,618	28,038	Total revenue and other support	1,172,413	1,096,739	75,674
			Operating expenses:			
101,556	90,938	(10,618)	Physician salaries	200,919	183,547	(17,372)
184,681	169,056	(15,625)	Staff salaries	361,168	328,716	(32,452)
67,234	63,455	(3,779)	Employee benefits	136,703	123,038	(13,665)
116,019	100,153	(15,866)	Medical supplies and medications	221,824	190,380	(31,444)
89,307	85,987	(3,320)	Purchased services and other	172,052	164,243	(7,809)
18,958	17,544	(1,414)	Medicaid enhancement tax	37,915	34,874	(3,041)
30,236	28,867	(1,369)	Depreciation, amortization and interest	59,296	57,503	(1,793)
607,991	556,000	(51,991)	Total operating expenses	1,189,877	1,082,301	(107,576)
(16,335)	7,618	(23,953)	Operating (loss) margin before DSH	(17,464)	14,438	(31,902)
15,335	14,175	1,160	Medicaid Uncompensated Care Payment (DSH)	30,644	28,263	2,381
$ (1,000)	$ 21,793	(22,793)	**Operating (loss) margin**	$ 13,180	$ 42,701	(29,521)
-0.2%	3.8%		**Operating margin (%)**	1.1%	3.8%	

Dartmouth-Hitchcock Health (Excludes Putnam)
Consolidated Key Performance Measures
For the Period Ended December 31, 2019

Current Quarter					Year-to-Date			
Actual	**Budget**	**Change**	**%**		**Actual**	**Budget**	**Change**	**%**
				Patient Access and Activity				
				Total Appointments (MD & AP)				
294,938	296,978	(2,040)	-0.7%	Dartmouth-Hitchcock**	589,990	588,168	1,822	0.3%
11,941	12,930	(989)	-7.6%	Alice Peck Day	23,398	24,877	(1,479)	-5.9%
59,600	61,969	(2,369)	-3.8%	Cheshire Medical Center	119,007	121,177	(2,170)	-1.8%
14,700	15,177	(477)	-3.1%	Mt. Ascutney Hospital & Health Center	29,196	30,278	(1,082)	-3.6%
17,849	17,594	255	1.4%	New London Hospital	35,404	36,224	(820)	-2.3%
399,028	404,648	(5,620)	-1.4%	Total	796,995	800,724	(3,729)	-0.5%
				Discharges*				
5,251	5,174	77	1.5%	Dartmouth-Hitchcock	10,667	10,416	251	2.4%
323	319	4	1.3%	Alice Peck Day	568	596	(28)	-4.6%
1,211	1,138	73	6.4%	Cheshire Medical Center	2,332	2,195	137	6.2%
273	264	9	3.3%	Mt. Ascutney Hospital & Health Center	557	532	25	4.6%
261	347	(86)	-24.8%	New London Hospital	521	693	(172)	-24.8%
7,319	7,242	77	1.1%	Total	14,645	14,432	213	1.5%
				Patient Days*				
28,607	28,937	(330)	-1.1%	Dartmouth-Hitchcock	58,414	58,956	(542)	-0.9%
1,224	1,325	(101)	-7.6%	Alice Peck Day	2,437	2,582	(145)	-5.6%
5,694	5,665	29	0.5%	Cheshire Medical Center	10,463	10,899	(436)	-4.0%
2,443	2,618	(175)	-6.7%	Mt. Ascutney Hospital & Health Center	4,890	5,265	(375)	-7.1%
1,345	1,458	(113)	-7.8%	New London Hospital	2,391	2,787	(396)	-14.2%
39,313	40,003	(690)	-1.7%	Total	78,595	80,489	(1,894)	-2.4%
				Average Length of Stay*				
5.45	5.59	(0.15)	-2.6%	Dartmouth-Hitchcock	5.48	5.66	(0.18)	-3.2%
3.79	4.16	(0.37)	-8.8%	Alice Peck Day	4.29	4.34	(0.05)	-1.0%
4.70	4.98	(0.28)	-5.5%	Cheshire Medical Center	4.49	4.97	(0.48)	-9.6%
8.95	9.91	(0.96)	-9.7%	Mt. Ascutney Hospital & Health Center	8.78	9.89	(1.11)	-11.2%
5.15	4.20	0.95	22.6%	New London Hospital	4.59	4.02	0.57	14.1%
5.37	5.52	(0.15)	-2.8%	Total	5.37	5.58	(0.21)	-3.8%
				Average Daily Census*				
310.9	314.5	(3.6)	-1.1%	Dartmouth-Hitchcock	317.5	320.4	(2.9)	-0.9%
13.3	14.4	(1.1)	-7.6%	Alice Peck Day	13.2	14.0	(0.8)	-5.4%
61.9	61.6	0.3	0.5%	Cheshire Medical Center	56.9	59.2	(2.3)	-3.9%
26.6	28.5	(1.9)	-6.8%	Mt. Ascutney Hospital & Health Center	26.6	28.6	(2.0)	-7.1%
14.6	15.8	(1.2)	-7.5%	New London Hospital	13.0	15.1	(2.1)	-13.9%
427.3	434.8	(7.5)	-1.7%	Total	427.2	437.3	(10.1)	-2.3%
				Surgical Cases				
5,967	5,881	86	1.5%	Dartmouth-Hitchcock	11,844	11,438	406	3.5%
668	541	127	23.4%	Alice Peck Day	1,224	1,006	218	21.7%
1,244	1,167	77	6.6%	Cheshire Medical Center	2,367	2,333	34	1.5%
415	451	(36)	-8.0%	Mt. Ascutney Hospital & Health Center	837	907	(70)	-7.7%
420	450	(30)	-6.7%	New London Hospital	857	850	7	0.8%
8,714	8,490	224	2.6%	Total	17,129	16,534	595	3.6%
				Staffing				
				Physician Full Time Equivalents (FTE)				
828.0	821.0	7.0	0.9%	Dartmouth-Hitchcock	814.4	814.8	(0.4)	0.0%
23.6	22.5	1.1	4.9%	Alice Peck Day	22.7	22.5	0.2	0.9%
115.7	108.8	6.9	6.3%	Cheshire Medical Center	114.1	108.5	5.6	5.2%
20.4	20.0	0.4	2.0%	Mt. Ascutney Hospital & Health Center	20.1	19.5	0.6	3.1%
22.2	25.0	(2.8)	-11.2%	New London Hospital	22.2	25.0	(2.8)	-11.2%
2.0	2.0	-	0.0%	Visiting Nurse and Hospice	2.0	2.0	-	0.0%
1,011.9	999.3	12.6	1.3%	Total	995.5	992.3	3.2	0.3%
				Non Physician Full Time Equivalents (FTE)				
7,863.9	7,900.5	(36.6)	-0.5%	Dartmouth-Hitchcock	7,828.8	7,869.9	(41.1)	-0.5%
372.0	405.2	(33.2)	-8.2%	Alice Peck Day	371.6	405.2	(33.6)	-8.3%
1,123.8	1,164.9	(41.1)	-3.5%	Cheshire Medical Center	1,128.3	1,163.8	(35.5)	-3.1%
342.5	347.0	(4.5)	-1.3%	Mt. Ascutney Hospital & Health Center	345.8	345.3	0.5	0.1%
435.2	451.8	(16.6)	-3.7%	New London Hospital	434.7	451.8	(17.1)	-3.8%
189.9	196.1	(6.2)	-3.2%	Visiting Nurse and Hospice	189.9	196.1	(6.2)	-3.2%
10,327.3	10,465.5	(138.2)	-1.3%	Total	10,299.1	10,432.1	(133.0)	-1.3%

* Excludes Newborn, Observation, ADMNO and SDNO **Includes Contractual Entities

Exhibit III

Consolidated Dartmouth-Hitchcock Health and Subsidiaries
Key Financial Health Measures

	Fiscal Year-20 Budget/ Covenant * Requirements	Fiscal Year Ended Jun-18	Fiscal Year Ended Jun-19	Six Months Ended Dec-19
Operating Margin (%)	2.5%	2.3%	3.0%	1.1%
Total Margin (%)	3.7%	2.7%	4.5%	4.7%
EBITDA (%)	8.8%	7.8%	9.6%	9.6%
Unrestricted Days Cash on Hand	153	158	162	152
Debt-to-Capitalization	56.9%	59.0%	57.3%	58.1%
Annual Debt Service Coverage *	>1.10x	5.68	6.67	4.54
Days in Accounts Receivable, net	36.3	43.2	40.4	39.0

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Balance Sheets
($ in 000s)

	December 2019	June 2019
Assets		
Current assets		
Cash and cash equivalents	$ 97,966	$ 143,587
Patient accounts receivable, net	217,029	221,125
Prepaid expenses and other current assets	145,817	95,495
Total current assets	460,812	460,207
Assets limited as to use		
Internally designated by board	850,142	809,538
Under bond indenture agreement held by trustee	105,682	630
Insurance deposits	66,082	66,082
Total assets limited as to use	1,021,906	876,250
Other investments for restricted activities	141,147	134,119
Property, plant and equipment, net	616,755	621,257
Right of use assets, net	64,232	-
Other assets	130,723	124,471
Total assets	$ 2,435,575	$ 2,216,304
Liabilities and Net Assets		
Current liabilities		
Current maturities of long-term debt	$ 10,737	$ 10,914
Current portion of lease obligations	12,293	-
Current portion of liability for other postretirement plan benefits	3,468	3,468
Accounts payable and accrued expenses	132,198	113,819
Accrued compensation and benefits	137,223	128,408
Estimated third party settlements	34,930	41,570
Total current liabilities	330,849	298,179
Long-term debt, excluding current portion	833,339	752,180
Long-term lease obligations, excluding current portion	52,593	-
Insurance deposits and related liabilities	58,387	58,407
Liability for pension and other postretirement plan benefits	265,463	281,009
Other liabilities	129,540	124,136
Total liabilities	1,670,171	1,513,911
Net assets		
Assets without donor restrictions	615,832	559,933
Assets with donor restrictions	149,572	142,460
Total net assets	765,404	702,393
Total liabilities and net assets	$ 2,435,575	$ 2,216,304

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Statement of Operations and Changes in Net Assets
For the Six Months Ended December 31, 2019 and 2018
($ in 000s)

	December 2019	December 2018
Revenue and other support		
Net patient service revenue	$ 992,547	$ 960,657
Contracted revenue	41,448	35,381
Other operating revenue	131,145	93,929
Net assets released from restrictions	7,273	6,772
Total revenue and other support	1,172,413	1,096,739
Operating expenses		
Salaries	562,087	512,263
Employee benefits	136,703	123,038
Medical supplies and medications	221,824	190,380
Purchased services and other	172,052	164,243
Medicaid enhancement tax	37,915	34,874
Depreciation and amortization	45,700	44,688
Interest	13,596	12,815
Total operating expenses	1,189,877	1,082,301
Operating (loss) margin before DSH	(17,464)	14,438
Medicaid Uncompensated Care Payment (DSH)	30,644	28,263
Operating margin	13,180	42,701
Nonoperating gains (losses)		
Investment gains (losses)	42,533	(28,090)
Other, net	2,501	(820)
Loss on early extinguishment of debt	-	(87)
Total nonoperating gains (losses)	45,034	(28,997)
Excess of revenue over expenses	58,214	13,704
Net assets without donor restrictions		
Net assets released from restrictions	792	571
Change in additional minimum pension liability	(3,107)	682
Increase in net assets without donor restrictions	55,899	14,957
Net assets with donor restrictions		
Gifts, bequests, sponsored activities	11,780	10,063
Investment gains	1,527	253
Change in net unrealized gains on investments	1,870	(1,964)
Net assets released from restrictions	(8,065)	(7,343)
Contribution of restricted net assets from acquisition	-	383
Increase in net assets with donor restrictions	7,112	1,392
Increase in net assets	63,011	16,349
Net assets, beginning of period	702,393	661,935
Net assets, end of period	$ 765,404	$ 678,284

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Statement of Cash Flows
For the Six Months Ended December 31, 2019 and 2018
($ in 000s)

	December 2019	December 2018
Cash flows from operating activities		
Change in net assets	$ 63,011	$ 16,349
Adjustments to reconcile change in net assets to		
net cash provided by operating and non-operating activities		
Depreciation and amortization	44,980	44,091
Amortization expense portion of lease expense	6,252	-
Principal payments on right of use lease obligations - operating	(4,608)	-
Contribution of revenue from acquisition	-	5,304
Change in funded status of pension and other postretirement benefits	3,107	(683)
Loss on disposal of fixed assets	143	(1,691)
Net realized gains and change in net unrealized gains on investments	(42,448)	29,347
Restricted contributions and investment earnings	(2,416)	(1,642)
Proceeds from sales of securities	187	775
Changes in assets and liabilities		
Patient accounts receivable, net	4,096	12,472
Prepaid expenses and other current assets	(50,322)	(24,394)
Other assets, net	(6,252)	1,580
Accounts payable and accrued expenses	18,382	31,359
Accrued compensation and related benefits	8,815	4,826
Estimated third-party settlements	(6,640)	(5,331)
Insurance deposits and related liabilities	(20)	116
Liability for pension and other postretirement benefits	(18,653)	(16,490)
Other liabilities	5,367	3,296
Net cash provided by operating and non-operating activities	22,981	99,284
Cash flows from investing activities		
Purchase of property, plant, and equipment	(57,343)	(33,905)
Proceeds from sale of property, plant, and equipment	-	2,064
Purchases of investments	(221,508)	(37,606)
Proceeds from maturities and sales of investments	111,081	27,436
Cash received through acquisition	-	7,469
Net cash used in investing activities	(167,770)	(34,542)
Cash flows from financing activities		
Proceeds from line of credit	5,000	-
Payments on line of credit	(5,000)	-
Repayment of long-term debt	(9,422)	(11,424)
Principal payments on capital leases	(932)	
Proceeds from issuance of debt	107,147	-
Payment of debt issuance costs	(41)	-
Restricted contributions and investment earnings	2,416	1,642
Net cash provided by (used in) financing activities	99,168	(9,782)
(Decrease) increase in cash and cash equivalents	(45,621)	54,960
Cash and cash equivalents		
Beginning of year	143,587	200,169
End of period	$ 97,966	$ 255,129

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
As of December 31, 2019
($ in 000s)

	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock and Subsidiaries	APDMH and Subsidiaries	Cheshire Medical Center and Subsidiaries	Mt Ascutney Hospital and Health Center and Subsidiaries	New London Hospital Association and Subsidiaries	Visiting Nurse and Hospice and Subsidiaries	Other	Eliminations	Dartmouth-Hitchcock Health and Subsidiaries
Assets										
Current assets										
Cash and cash equivalents	$ 4,479	46,293	9,200	14,174	8,702	8,282	6,214	622	-	97,966
Patient accounts receivable, net	-	175,457	7,060	17,798	4,301	9,800	2,613	-	-	217,029
Prepaid expenses and other current assets	12,326	156,522	4,349	16,618	1,754	6,355	628	812	(53,547)	145,817
Total current assets	16,805	378,272	20,609	48,590	14,757	24,437	9,455	1,434	(53,547)	460,812
Assets limited as to use										
Internally designated by board	93,911	656,252	13,399	17,384	13,707	13,300	22,046	20,143	-	850,142
Under bond indenture agreement held by trustee	105,060	105,603	72	-	-	-	-	-	(105,053)	105,682
Insurance deposits	-	66,082	-	-	-	-	-	-	-	66,082
Total assets limited as to use	198,971	827,937	13,471	17,384	13,707	13,300	22,046	20,143	(105,053)	1,021,906
Notes receivable, related party	660,470	667	-	-	-	-	-	-	(661,137)	-
Other investments for restricted activities	-	97,564	31	26,202	6,451	3,005	-	7,894	-	141,147
Property, plant and equipment, net	15	438,512	41,418	69,694	19,517	41,673	3,250	2,676	-	616,755
Right of use assets, net	-	39,126	16,765	3,782	3,682	767	110	-	-	64,232
Other assets	25,277	114,229	8,209	7,441	2,198	5,471	46	168	(32,316)	130,723
Total assets	$ 901,538	1,896,307	100,503	173,093	60,312	88,653	34,907	32,315	(852,053)	2,435,575
Liabilities and Net Assets										
Current liabilities										
Current maturities of long-term debt	$ -	8,411	752	845	260	400	69	-	-	10,737
Current portion of lease obligations	-	8,334	764	955	1,856	321	63	-	-	12,293
Current portion of liability for other postretirement plan benefits	-	3,468	-	-	-	-	-	-	-	3,468
Accounts payable and accrued expenses	125,667	123,572	4,753	27,763	3,258	3,319	1,864	602	(158,600)	132,198
Accrued compensation and benefits	-	118,799	4,144	5,309	4,543	3,068	1,360	-	-	137,223
Estimated third party settlements	851	20,972	1,412	120	1,643	9,932	-	-	-	34,930
Total current liabilities	126,518	283,556	11,825	34,992	11,560	17,040	3,356	602	(158,600)	330,849
Notes payable, related party	-	633,260	-	-	-	27,877	-	-	(661,137)	-
Long-term debt, excluding current portion	749,664	32,553	24,306	23,648	11,612	-	2,526	-	(10,970)	833,339
Long-term lease obligations, excluding current portion	-	31,141	16,178	2,827	1,826	574	47	-	-	52,593
Insurance deposits and related liabilities	-	56,786	513	441	220	388	39	-	-	58,387
Liability for pension and other postretirement plan benefits	-	248,679	-	9,390	7,394	-	-	-	-	265,463
Other liabilities	-	104,154	22,655	1,126	-	1,605	-	-	-	129,540
Total liabilitites	876,182	1,390,129	75,477	72,424	32,612	47,484	5,968	602	(830,707)	1,670,171
Net assets										
Net assets without donor restrictions	25,351	409,294	23,482	69,791	20,175	36,482	28,909	23,654	(21,306)	615,832
Net assets with donor restrictions	5	96,884	1,544	30,878	7,525	4,687	30	8,059	(40)	149,572
Total net assets	25,356	506,178	25,026	100,669	27,700	41,169	28,939	31,713	(21,346)	765,404
Total liabilities and net assets	$ 901,538	1,896,307	100,503	173,093	60,312	88,653	34,907	32,315	(852,053)	2,435,575
Unrestricted Days Cash on Hand	**1,005**	**137** ^	**111**	**52**	**154**	**125**	**442**	**2,054**	**-**	**152**
Debt-to-Capitalization	**96.7%**	**62.0%**	**63.1%**	**25.3%**	**37.7%**	**43.8%**	**8.0%**	**-**	**-**	**58.1%**
Days in Accounts Receivable, net	**-**	**39.3**	**37.4**	**31.6**	**38.3**	**58.9**	**42.2**	**-**	**-**	**39.0**

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Net Assets
For the Six Months Ended December 31, 2019
($ in 000s)

	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock and Subsidiaries	APDMH and Subsidiaries	Cheshire Medical Center and Subsidiaries	Mt Ascutney Hospital and Health Center and Subsidiaries	New London Hospital Association and Subsidiaries	Visiting Nurse and Hospice and Subsidiaries	Other	Eliminations	Dartmouth-Hitchcock Health and Subsidiaries
Revenue and other support										
Net patient service revenue	$ -	786,091	32,873	112,535	20,486	29,157	11,405	-	-	992,547
Contracted revenue	2,339	59,003	-	401	6,022	9	-	356	(26,682)	41,448
Other operating revenue	11,837	118,673	5,159	2,543	1,973	2,357	301	752	(12,450)	131,145
Net assets released from restrictions	113	6,369	169	54	44	90	-	434	-	7,273
Total revenue and other support	14,289	970,136	38,201	115,533	28,525	31,613	11,706	1,542	(39,132)	1,172,413
Operating expenses										
Salaries	-	465,387	19,576	56,664	14,033	17,026	6,149	-	(16,748)	562,087
Employee benefits	-	113,655	3,734	13,193	3,358	3,551	1,325	-	(2,113)	136,703
Medical supplies and medications	-	192,895	4,729	19,270	1,509	2,708	713	-	-	221,824
Purchased services and other	6,936	132,497	7,268	17,267	6,909	6,509	3,545	1,861	(10,740)	172,052
Medicaid enhancement tax	-	29,719	1,594	4,253	874	1,475	-	-	-	37,915
Depreciation and amortization	7	35,366	2,185	4,654	1,270	2,026	192	-	-	45,700
Interest	11,083	11,414	647	477	114	552	31	-	(10,722)	13,596
Total operating expenses	18,026	980,933	39,733	115,778	28,067	33,847	11,955	1,861	(40,323)	1,189,877
Operating (loss) margin before DSH	(3,737)	(10,797)	(1,532)	(245)	458	(2,234)	(249)	(319)	1,191	(17,464)
Medicaid Uncompensated Care Payment (DSH)	-	24,250	1,850	2,872	197	1,475	-	-	-	30,644
Operating (loss) margin	(3,737)	13,453	318	2,627	655	(759)	(249)	(319)	1,191	13,180
Operating (loss) margin %	(26.2%)	1.4%	0.8%	2.2%	2.3%	(2.3%)	(2.1%)	(20.7%)	3.0%	1.1%
Nonoperating gains (losses)										
Investment gains (losses)	2,044	35,054	618	570	912	859	1,247	1,328	(99)	42,533
Other, net	(1,890)	4,109	-	677	100	8	589	-	(1,092)	2,501
Total nonoperating gains (losses)	154	39,163	618	1,247	1,012	867	1,836	1,328	(1,191)	45,034
(Deficiency) excess of revenue over expense	(3,583)	52,616	936	3,874	1,667	108	1,587	1,009	-	58,214
Net assets without donor restrictions										
Net assets released from restrictions	-	134	-	44	300	287	-	27	-	792
Change in additional minimum pension liability	-	-	-	-	(3,107)	-	-	-	-	(3,107)
Net assets transferred to (from) affiliate	102	(336)	219	-	15	-	-	-	-	-
(Decrease) increase in net assets without donor restrictions	(3,481)	52,414	1,155	3,918	(1,125)	395	1,587	1,036	-	55,899
Net assets with donor restrictions										
Gifts, bequests, sponsored activities	7,598	2,849	60	638	44	384	-	207	-	11,780
Investment gains	1	714	-	488	171	61	-	92	-	1,527
Change in net unrealized gains on investments	-	1,221	-	290	218	-	-	141	-	1,870
Net assets released from restrictions	(113)	(6,503)	(169)	(98)	(344)	(377)	-	(461)	-	(8,065)
Gifts received by DHH transferred to DH	(7,499)	7,499	-	-	-	-	-	-	-	-
(Decrease) increase in net assets with donor restrictions	(13)	5,780	(109)	1,318	89	68	-	(21)	-	7,112
(Decrease) increase in net assets	(3,494)	58,194	1,046	5,236	(1,036)	463	1,587	1,015	-	63,011
Net assets, beginning of period	28,850	447,984	23,980	95,433	28,736	40,706	27,352	30,698	(21,346)	702,393
Net assets, end of period	$ 25,356	506,178	25,026	100,669	27,700	41,169	28,939	31,713	(21,346)	765,404

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations - Variance to Budget
For the Six Months Ended December 31, 2019
($ in 000s)

	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock and Subsidiaries	APDMH and Subsidiaries	Cheshire Medical Center and Subsidiaries	Mt Ascutney Hospital and Health Center and Subsidiaries	New London Hospital Association and Subsidiaries	Visiting Nurse and Hospice and Subsidiaries	Other and Subsidiaries	Eliminations	Dartmouth-Hitchcock Health and Subsidiaries
Revenue and other support										
Net patient service revenue	$ -	(6,485)	(1,385)	3,859	(3,290)	(3,316)	(461)	-	-	(11,078)
Contracted revenue	2,039	1,718	-	400	2,948	7	-	356	(4,414)	3,054
Other operating revenue	1,227	8,963	155	(958)	(81)	96	(14)	(1,541)	(1,193)	6,654
Net assets released from restrictions	(52)	478	14	(95)	35	79	-	434	-	893
Total revenue and other support	3,214	4,674	(1,216)	3,206	(388)	(3,134)	(475)	(751)	(5,607)	(477)
Operating expenses										
Salaries	-	(10,214)	1,174	(830)	34	(163)	224	-	5,600	(4,175)
Employee benefits	-	(1,577)	910	145	859	269	276	-	460	1,342
Medical supplies and medications	-	(15,507)	(108)	(821)	5	45	(42)	-	-	(16,428)
Purchased services and other	(1,143)	(168)	1,002	50	246	905	320	445	(798)	859
Medicaid enhancement tax	-	-	-	-	54	-	-	-	-	54
Depreciation and amortization	1	2,794	964	(213)	5	6	-	-	-	3,557
Interest	(748)	(734)	134	21	9	4	-	-	301	(1,013)
Total operating expenses	(1,890)	(25,406)	4,076	(1,648)	1,212	1,066	778	445	5,563	(15,804)
Operating margin (loss) before DSH	1,324	(20,732)	2,860	1,558	824	(2,068)	303	(306)	(44)	(16,281)
Medicaid Uncompensated Care Payment (DSH)	-	-	-	-	37	-	-	-	-	37
Operating margin (loss)	$ 1,324	(20,732)	2,860	1,558	861	(2,068)	303	(306)	(44)	(16,244)
Total revenue before DSH favorable/(unfavorable) variance %	**29.0%**	**0.5%**	**(3.1%)**	**2.9%**	**(1.3%)**	**(9.0%)**	**(3.9%)**	**(32.8%)**	**16.7%**	**-**
Total expense (unfavorable)/favorable variance %	**(11.7%)**	**(2.7%)**	**9.3%**	**(1.4%)**	**4.1%**	**3.1%**	**6.1%**	**19.3%**	**(16.0%)**	**(1.3%)**

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations - Variance to Budget
For the Quarter Ended December 31, 2019
($ in 000s)

	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock and Subsidiaries	APDMH and Subsidiaries	Cheshire Medical Center and Subsidiaries	Mt Ascutney Hospital and Health Center and Subsidiaries	New London Hospital Association and Subsidiaries	Visiting Nurse and Hospice and Subsidiaries	Other	Eliminations	Dartmouth-Hitchcock Health and Subsidiaries
Revenue and other support										
Net patient service revenue	$ -	(5,766)	(469)	2,500	717	(2,035)	(256)	-	-	(5,309)
Contracted revenue	2,039	(1,858)	-	(1)	728	-	-	160	(2,271)	(1,203)
Other operating revenue	1,227	6,050	55	(651)	(268)	144	4	(736)	(814)	5,011
Net assets released from restrictions	(78)	571	54	(27)	22	50	-	265	-	857
Total revenue and other support	3,188	(1,003)	(360)	1,821	1,199	(1,841)	(252)	(311)	(3,085)	(644)
Operating expenses										
Salaries	-	(4,895)	569	(192)	(255)	(132)	124	-	2,652	(2,129)
Employee benefits	-	1,261	240	84	275	(26)	186	-	185	2,205
Medical supplies and medications	-	(11,206)	(161)	(194)	98	105	(38)	-	-	(11,396)
Purchased services and other	(1,119)	(786)	564	(599)	(74)	395	145	248	(117)	(1,343)
Medicaid enhancement tax	-	-	-	-	38	-	-	-	-	38
Depreciation and amortization	-	1,395	463	(132)	7	-	-	-	-	1,733
Interest	(747)	(726)	119	10	-	4	-	-	300	(1,040)
Total operating expenses	(1,866)	(14,957)	1,794	(1,023)	89	346	417	248	3,020	(11,932)
Operating margin (loss) before DSH	1,322	(15,960)	1,434	798	1,288	(1,495)	165	(63)	(65)	(12,576)
Medicaid Uncompensated Care Payment (DSH)	-	-	-	(1)	27	-	-	-	-	26
Operating margin (loss)	$ 1,322	(15,960)	1,434	797	1,315	(1,495)	165	(63)	(65)	(12,550)
Total revenue before DSH favorable/(unfavorable) variance %	**57.6%**	**(0.2%)**	**(1.7%)**	**3.2%**	**8.3%**	**(10.5%)**	**(4.1%)**	**(27.1%)**	**18.4%**	**(0.1%)**
Total expense (unfavorable)/favorable variance %	**(23.1%)**	**(3.1%)**	**8.1%**	**(1.8%)**	**0.6%**	**2.0%**	**6.5%**	**21.5%**	**(17.4%)**	**(2.0%)**

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
As of December 31, 2018
($ in 000s)

	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock and Subsidiaries	APDMH and Subsidiaries	Cheshire Medical Center and Subsidiaries	Mt Ascutney Hospital and Health Center and Subsidiaries	New London Hospital Association and Subsidiaries	Visiting Nurse and Hospice and Subsidiaries	Other	Eliminations	Dartmouth-Hitchcock Health and Subsidiaries
Assets										
Current assets										
Cash and cash equivalents	$ 137,070	67,812	8,552	18,241	6,547	10,487	5,811	609	-	255,129
Patient accounts receivable, net	-	164,878	8,328	14,362	6,292	9,421	3,475	-	-	206,756
Prepaid expenses and other current assets	12,294	174,279	3,707	3,903	1,655	5,695	572	520	(82,184)	120,441
Total current assets	149,364	406,969	20,587	36,506	14,494	25,603	9,858	1,129	(82,184)	582,326
Assets limited as to use										
Internally designated by board	-	525,285	16,813	17,384	11,591	11,201	18,133	17,300	-	617,707
Under bond indenture agreement held by trustee	8	550	72	764	-	-	-	-	-	1,394
Insurance deposits	-	67,938	-	-	-	-	-	-	-	67,938
Total assets limited as to use	8	593,773	16,885	18,148	11,591	11,201	18,133	17,300	-	687,039
Notes receivable, related party	554,127	-	-	-	-	-	-	-	(554,127)	-
Other investments for restricted activities	-	89,388	130	23,393	5,830	3,333	-	7,962	-	130,036
Property, plant and equipment, net	29	435,226	50,474	67,143	19,779	42,424	3,037	2,675	-	620,787
Other assets	24,696	95,259	5,378	7,350	1,739	5,089	101	158	(32,316)	107,454
Total assets	$ 728,224	1,620,615	93,454	152,540	53,433	87,650	31,129	29,224	(668,627)	2,127,642
Liabilities and Net Assets										
Current liabilities										
Current maturities of long-term debt	$ -	1,031	1,022	831	220	563	67	-	-	3,734
Current portion of liability for other postretirement plan benefits	-	3,311	-	-	-	-	-	-	-	3,311
Accounts payable and accrued expenses	57,558	114,536	3,876	21,347	3,494	6,689	2,117	287	(82,184)	127,720
Accrued compensation and benefits	-	112,567	4,729	5,513	4,461	2,506	1,123	-	-	130,899
Estimated third party settlements	-	21,448	2,448	1	1,420	10,493	-	-	-	35,810
Total current liabilities	57,558	252,893	12,075	27,692	9,595	20,251	3,307	287	(82,184)	301,474
Notes payable, related party	-	526,774	-	-	-	27,353	-	-	(554,127)	-
Long-term debt, excluding current portion	643,888	52,401	25,083	24,514	11,492	906	2,596	-	(10,970)	749,910
Insurance deposits and related liabilities	-	54,616	513	466	240	272	39	-	-	56,146
Liability for pension and other postretirement plan benefits	-	217,173	-	3,362	4,519	-	-	-	-	225,054
Other liabilities	-	80,552	33,810	1,081	-	1,331	-	-	-	116,774
Total liabilitites	701,446	1,184,409	71,481	57,115	25,846	50,113	5,942	287	(647,281)	1,449,358
Net assets										
Net assets without donor restrictions	26,737	347,567	20,984	65,523	20,882	32,695	25,157	20,820	(21,306)	539,059
Net assets with donor restrictions	41	88,639	989	29,902	6,705	4,842	30	8,117	(40)	139,225
Total net assets	26,778	436,206	21,973	95,425	27,587	37,537	25,187	28,937	(21,346)	678,284
Total liabilities and net assets	$ 728,224	1,620,615	93,454	152,540	53,433	87,650	31,129	29,224	(668,627)	2,127,642
Unrestricted Days Cash on Hand	**1,680**	**138 ^**	**122**	**63**	**123**	**126**	**382**	**1,758**	**-**	**155**
Debt-to-Capitalization	**96.0%**	**62.5%**	**54.4%**	**27.2%**	**35.5%**	**46.4%**	**9.4%**	**-**	**-**	**58.2%**
Days in Accounts Receivable, net	**-**	**37.7**	**44.1**	**32.3**	**45.5**	**55.2**	**55.6**	**-**	**-**	**38.5**

^ Unrestricted Days Cash on Hand calculation for DH includes $40M of investments held by D-HH. The $40M amount in the DH calculation is removed for the consolidated calculation.

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Net Assets
For the Six Months Ended December 31, 2018
($ in 000s)

	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock and Subsidiaries	APDMH and Subsidiaries	Cheshire Medical Center and Subsidiaries	Mt Ascutney Hospital and Health Center and Subsidiaries	New London Hospital Association and Subsidiaries	Visiting Nurse and Hospice and Subsidiaries	Other	Eliminations	Dartmouth-Hitchcock Health and Subsidiaries
Revenue and other support										
Net patient service revenue	$ -	753,061	32,932	107,613	25,155	30,399	11,497	-	-	960,657
Contracted revenue	3,316	52,242	-	363	1,345	-	-	283	(22,168)	35,381
Other operating revenue	10,601	81,151	6,081	1,949	1,928	1,998	255	1,136	(11,170)	93,929
Net assets released from restrictions	101	5,862	115	126	9	105	-	454	-	6,772
Total revenue and other support	14,018	892,316	39,128	110,051	28,437	32,502	11,752	1,873	(33,338)	1,096,739
Operating expenses										
Salaries	-	423,786	20,139	51,596	13,357	15,572	5,703	-	(17,890)	512,263
Employee benefits	-	100,506	4,127	12,667	3,888	3,434	1,392	-	(2,976)	123,038
Medical supplies and medications	-	163,085	4,145	17,549	1,575	3,307	719	-	-	190,380
Purchased services and other	4,668	116,702	7,569	17,806	7,274	7,510	3,699	1,874	(2,859)	164,243
Medicaid enhancement tax	-	27,105	1,512	4,049	858	1,350	-	-	-	34,874
Depreciation and amortization	7	34,409	1,728	5,121	1,230	2,023	170	-	-	44,688
Interest	10,342	10,780	872	547	112	558	32	-	(10,428)	12,815
Total operating expenses	15,017	876,373	40,092	109,335	28,294	33,754	11,715	1,874	(34,153)	1,082,301
Operating (loss) margin before DSH	(999)	15,943	(964)	716	143	(1,252)	37	(1)	815	14,438
Medicaid Uncompensated Care Payment (DSH)	-	22,676	1,850	2,465	272	1,000	-	-	-	28,263
Operating (loss) margin	(999)	38,619	886	3,181	415	(252)	37	(1)	815	42,701
Operating (loss) margin %	(7.1%)	4.2%	2.2%	2.8%	1.4%	(0.8%)	0.3%	(0.1%)	2.4%	3.8%
Nonoperating gains (losses)										
Investment gains (losses)	1,187	(22,335)	(827)	(2,984)	(443)	(505)	(1,215)	(869)	(99)	(28,090)
Other, net	(1,893)	1,165	-	(26)	148	51	451	-	(716)	(820)
Loss on early extinguishment of debt	-	-	(87)	-	-	-	-	-	-	(87)
Total nonoperating losses	(706)	(21,170)	(914)	(3,010)	(295)	(454)	(764)	(869)	(815)	(28,997)
(Deficiency) excess of revenue over expense	(1,705)	17,449	(28)	171	120	(706)	(727)	(870)	-	13,704
Net assets without donor restrictions										
Net assets released from restrictions	-	178	(19)	24	316	18	-	54	-	571
Change in additional minimum pension liability	-	-	-	-	682	-	-	-	-	682
Net assets transferred to (from) affiliate	4,683	(4,942)	-	259	-	-	-	-	-	-
Increase (decrease) in net assets without donor restrictions	2,978	12,685	(47)	454	1,118	(688)	(727)	(816)	-	14,957
Net assets with donor restrictions										
Gifts, bequests, sponsored activities	6,542	2,199	73	282	63	467	-	437	-	10,063
Investment (losses) gains	(1)	481	(1)	(46)	(98)	(142)	-	60	-	253
Change in net unrealized gains on investments	-	(1,298)	(4)	(140)	(336)	-	-	(186)	-	(1,964)
Net assets released from restrictions	(101)	(6,040)	(96)	(150)	(325)	(123)	-	(508)	-	(7,343)
Contribution of assets with donor restrictions from acquisition	-	-	383	-	-	-	-	-	-	383
Gifts received by DHH transferred to DH	(6,399)	6,399	-	-	-	-	-	-	-	-
Increase (decrease) in net assets with donor restrictions	41	1,741	355	(54)	(696)	202	-	(197)	-	1,392
Increase (decrease) in net assets	3,019	14,426	308	400	422	(486)	(727)	(1,013)	-	16,349
Net assets, beginning of period	23,759	421,780	21,665	95,025	27,165	38,023	25,914	29,950	(21,346)	661,935
Net assets, end of period	$ 26,778	436,206	21,973	95,425	27,587	37,537	25,187	28,937	(21,346)	678,284

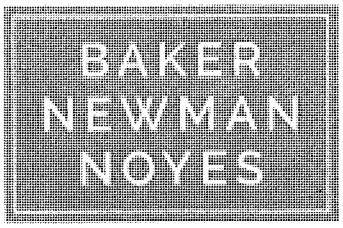
Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
As of June 30, 2019
($ in 000s)

	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock and Subsidiaries	APDMH and Subsidiaries	Cheshire Medical Center and Subsidiaries	Mt Ascutney Hospital and Health Center and Subsidiaries	New London Hospital Association and Subsidiaries	Visiting Nurse and Hospice and Subsidiaries	Other	Eliminations	Dartmouth-Hitchcock Health and Subsidiaries
Assets										
Current assets										
Cash and cash equivalents	$ 42,456	47,465	15,772	11,951	8,549	11,120	5,686	588	-	143,587
Patient accounts receivable, net	-	180,939	7,280	15,878	5,061	8,960	3,007	-	-	221,125
Prepaid expenses and other current assets	14,178	139,034	1,678	9,460	1,401	5,567	471	798	(77,092)	95,495
Total current assets	56,634	367,438	24,730	37,289	15,011	25,647	9,164	1,386	(77,092)	460,207
Assets limited as to use										
Internally designated by board	92,594	621,853	12,612	17,385	12,738	12,427	20,817	19,112	-	809,538
Under bond indenture agreement held by trustee	8	550	72	-	-	-	-	-	-	630
Insurance deposits	-	66,082	-	-	-	-	-	-	-	66,082
Total assets limited as to use	92,602	688,485	12,684	17,385	12,738	12,427	20,817	19,112	-	876,250
Notes receivable, related party	553,484	752	-	-	-	-	-	-	(554,236)	-
Other investments for restricted activities	-	91,882	31	24,985	6,323	2,973	-	7,925	-	134,119
Property, plant and equipment, net	22	432,277	50,338	70,848	19,435	42,423	3,239	2,675	-	621,257
Other assets	24,865	108,208	8,688	7,388	1,931	5,476	73	158	(32,316)	124,471
Total assets	$ 727,607	1,689,042	96,471	157,895	55,438	88,946	33,293	31,256	(663,644)	2,216,304
Liabilities and Net Assets										
Current liabilities										
Current maturities of long-term debt	$ -	8,226	954	830	288	547	69	-	-	10,914
Current portion of liability for other postretirement plan benefits	-	3,468	-	-	-	-	-	-	-	3,468
Accounts payable and accrued expenses	55,500	99,885	6,703	19,357	2,856	3,879	2,173	558	(77,092)	113,819
Accrued compensation and benefits	-	110,639	4,192	5,850	4,314	2,313	1,100	-	-	128,408
Estimated third party settlements	-	26,404	1,290	104	2,921	10,851	-	-	-	41,570
Total current liabilities	55,500	248,622	13,139	26,141	10,379	17,590	3,342	558	(77,092)	298,179
Notes payable, related party	-	526,202	-	-	-	28,034	-	-	(554,236)	-
Long-term debt, excluding current portion	643,257	44,820	35,604	24,503	11,763	643	2,560	-	(10,970)	752,180
Insurance deposits and related liabilities	-	56,786	513	441	240	388	39	-	-	58,407
Liability for pension and other postretirement plan benefits	-	266,427	-	10,262	4,320	-	-	-	-	281,009
Other liabilities	-	98,201	23,235	1,115	-	1,585	-	-	-	124,136
Total liabilitites	698,757	1,241,058	72,491	62,462	26,702	48,240	5,941	558	(642,298)	1,513,911
Net assets										
Net assets without donor restrictions	28,832	356,880	22,327	65,873	21,300	36,087	27,322	22,618	(21,306)	559,933
Net assets with donor restrictions	18	91,104	1,653	29,560	7,436	4,619	30	8,080	(40)	142,460
Total net assets	28,850	447,984	23,980	95,433	28,736	40,706	27,352	30,698	(21,346)	702,393
Total liabilities and net assets	$ 727,607	1,689,042	96,471	157,895	55,438	88,946	33,293	31,256	(663,644)	2,216,304
Unrestricted Days Cash on Hand	**1,538**	**148** ^	**130**	**51**	**144**	**146**	**419**	**1,800**	**-**	**162**
Debt-to-Capitalization	**95.7%**	**61.5%**	**61.5%**	**27.1%**	**35.6%**	**44.3%**	**8.6%**	**-**	**-**	**57.3%**
Days in Accounts Receivable, net	**-**	**40.4**	**38.1**	**35.1**	**40.1**	**54.4**	**48.7**	**-**	**-**	**40.4**

^ Unrestricted Days Cash on Hand calculation for DH includes $40M of investments held by D-HH. The $40M amount in the DH calculation is removed for the consolidated calculation.

Attachment 5

CMCHS Audited Financial Statements FY 2019



CMC Healthcare System, Inc.

Audited Consolidated Financial Statements and Other Financial Information

Years Ended September 30, 2019 and 2018
With Independent Auditors' Report

Baker Newman & Noyes LLC
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CMC HEALTHCARE SYSTEM, INC.

AUDITED CONSOLIDATED FINANCIAL STATEMENTS
AND OTHER FINANCIAL INFORMATION

Years Ended September 30, 2019 and 2018

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INDEPENDENT AUDITORS' REPORT

Board of Trustees
CMC Healthcare System, Inc.

We have audited the accompanying consolidated financial statements of CMC Healthcare System, Inc., which comprise the consolidated balance sheets as of September 30, 2019 and 2018, and the related consolidated statements of operations, changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

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

Board of Trustees
CMC Healthcare System, Inc.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of CMC Healthcare System, Inc. as of September 30, 2019 and 2018, and the results of its operations, changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter

As discussed in Note 2 to the consolidated financial statements, in 2019, CMC Healthcare System, Inc. adopted the provisions of Financial Accounting Standards Board Accounting Standards Update No. 2016-14, *Not-for-Profit Entities (Topic 958) - Presentation of Financial Statements of Not-for-Profit Entities* and applied the guidance retrospectively for all periods presented. Our opinion is not modified with respect to this matter.

Baker Newman & Noyes LLC

Manchester, New Hampshire
February 4, 2020

CMC HEALTHCARE SYSTEM, INC.

CONSOLIDATED BALANCE SHEETS

September 30, 2019 and 2018

ASSETS

	2019	2018
Current assets:		
Cash and cash equivalents	$ 56,249,490	$ 61,849,320
Short-term investments	4,021,270	29,009,260
Accounts receivable, less allowance for doubtful accounts of $20,265,887 in 2019 and $20,526,837 in 2018	79,322,642	55,326,986
Inventories	4,600,802	3,583,228
Other current assets	14,198,223	10,664,957
Total current assets	158,392,427	160,433,751
Property, plant and equipment, net	143,111,363	134,597,894
Other assets:		
Intangible assets and other	18,600,614	17,581,549
Assets whose use is limited:		
Pension and insurance obligations	18,832,810	17,859,458
Board designated and donor restricted investments and restricted grants	129,341,870	127,267,085
Held by trustee under revenue bond agreements	18,845,355	36,660,053
	167,020,035	181,786,596
Total assets	$487,124,439	$494,399,790

LIABILITIES AND NET ASSETS

	2019	2018
Current liabilities:		
Accounts payable and accrued expenses	$ 38,985,902	$ 30,789,153
Accrued salaries, wages and related accounts	22,973,478	22,673,489
Amounts payable to third-party payors	11,456,467	14,643,104
Current portion of long-term debt	4,158,079	4,365,199
Total current liabilities	77,573,926	72,470,945
Accrued pension and other liabilities, less current portion	172,049,836	122,463,230
Long-term debt, less current portion	121,883,751	122,913,717
Total liabilities	371,507,513	317,847,892
Net assets:		
Without donor restrictions	104,372,035	166,125,080
With donor restrictions	11,244,891	10,426,818
Total net assets	115,616,926	176,551,898
Total liabilities and net assets	$487,124,439	$494,399,790

See accompanying notes.

CMC HEALTHCARE SYSTEM, INC.

CONSOLIDATED STATEMENTS OF OPERATIONS

Years Ended September 30, 2019 and 2018

	2019	2018
Net patient service revenues, net of contractual allowances and discounts	$465,757,562	$452,510,375
Provision for doubtful accounts	(21,644,644)	(20,334,249)
Net patient service revenues less provision for doubtful accounts	444,112,918	432,176,126
Other revenue	21,610,585	19,454,686
Disproportionate share funding	22,566,094	17,993,289
Total revenues	488,289,597	469,624,101
Expenses:		
Salaries, wages and fringe benefits	284,646,960	266,813,278
Supplies and other	169,119,057	160,290,214
New Hampshire Medicaid enhancement tax	21,382,132	19,968,497
Depreciation and amortization	16,902,437	16,136,984
Interest	4,224,046	4,368,765
Total expenses	496,274,632	467,577,738
(Loss) income from operations	(7,985,035)	2,046,363
Nonoperating gains (losses):		
Investment income, net	4,120,862	6,086,794
Net periodic pension cost, other than service cost	(640,624)	(1,099,092)
Contributions without donor restrictions	834,004	629,198
Development costs	(739,596)	(635,408)
Other nonoperating loss	(3,135,699)	(489,294)
Total nonoperating gains, net	438,947	4,492,198
(Deficiency) excess of revenues and gains over expenses	(7,546,088)	6,538,561
Unrealized appreciation on investments	912,170	2,325,151
Change in fair value of interest rate swap agreement	(482,735)	302,826
Assets released from restriction used for capital	434,010	128,600
Pension-related changes other than net periodic pension cost	(55,070,402)	20,436,931
Change in net assets without donor restrictions	(61,753,045)	29,732,069
Net assets without donor restrictions at beginning of year	166,125,080	136,393,011
Net assets without donor restrictions at end of year	$104,372,035	$166,125,080

See accompanying notes.

CMC HEALTHCARE SYSTEM, INC.

CONSOLIDATED STATEMENTS OF CHANGES IN NET ASSETS

Years Ended September 30, 2019 and 2018

	Net Assets Without Donor Restrictions	Net Assets With Donor Restrictions	Total Net Assets
Balances at September 30, 2017	$136,393,011	$ 9,726,007	$146,119,018
Excess of revenues and gains over expenses	6,538,561	–	6,538,561
Restricted investment income	–	27,373	27,373
Changes in interest in perpetual trust	–	341,439	341,439
Donor restricted contributions	–	646,924	646,924
Unrealized appreciation on investments	2,325,151	61,431	2,386,582
Change in fair value of interest rate swap agreement	302,826	–	302,826
Assets released from restriction used for operations	–	(247,756)	(247,756)
Assets released from restriction used for capital	128,600	(128,600)	–
Pension-related changes other than net periodic pension cost	20,436,931	–	20,436,931
	29,732,069	700,811	30,432,880
Balances at September 30, 2018	166,125,080	10,426,818	176,551,898
Deficiency of revenues and gains over expenses	(7,546,088)	–	(7,546,088)
Restricted investment income	–	31,596	31,596
Changes in interest in perpetual trust	–	(110,168)	(110,168)
Donor restricted contributions	–	1,536,316	1,536,316
Unrealized appreciation on investments	912,170	15,219	927,389
Change in fair value of interest rate swap agreement	(482,735)	–	(482,735)
Assets released from restriction used for operations	–	(220,880)	(220,880)
Assets released from restriction used for capital	434,010	(434,010)	–
Pension-related changes other than net periodic pension cost	(55,070,402)	–	(55,070,402)
	(61,753,045)	818,073	(60,934,972)
Balances at September 30, 2019	$104,372,035	$11,244,891	$115,616,926

See accompanying notes.

CMC HEALTHCARE SYSTEM, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

Years Ended September 30, 2019 and 2018

	2019	2018
Operating activities:		
Change in net assets	$ (60,934,972)	$ 30,432,880
Adjustments to reconcile change in net assets to net cash (used) provided by operating activities:		
Depreciation and amortization	16,902,437	16,136,984
Pension-related changes other than net periodic pension cost	55,070,402	(20,436,931)
Restricted gifts and investment income	(1,567,912)	(674,297)
Net realized and unrealized gains on investments	(803,714)	(5,304,630)
Change in interest in perpetual trust	110,168	(341,439)
Change in fair value of interest rate swap agreement	482,735	(487,593)
Bond discount/premium and issuance cost amortization	(289,968)	(313,993)
Change in operating assets and liabilities:		
Accounts receivable, net	(23,995,656)	(5,828,809)
Inventories	(1,017,574)	(176,498)
Other current assets	(3,533,266)	1,711,535
Other assets	(1,049,682)	(1,031,639)
Accounts payable and accrued expenses	6,945,059	(5,312,460)
Accrued salaries, wages and related accounts	299,989	2,561,918
Amounts payable to third-party payors	(3,186,637)	291,872
Accrued pension and other liabilities	(5,978,340)	6,039,303
Net cash (used) provided by operating activities	(22,546,931)	17,266,203
Investing activities:		
Purchases of property, plant and equipment	(24,121,790)	(36,812,874)
Net change in assets held by trustee under revenue bond agreements	17,814,698	14,819,012
Proceeds from sales of investments	54,831,303	32,671,019
Purchases of investments	(31,397,904)	(40,605,899)
Net cash provided (used) by investing activities	17,126,307	(29,928,742)
Financing activities:		
Payments on long-term debt	(3,689,000)	(11,509,593)
Proceeds from issuance of long-term debt	3,513,632	8,130,000
Payments on capital leases	(676,199)	(707,299)
Bond issuance costs	(95,551)	(120,118)
Restricted gifts and investment income	767,912	674,297
Net cash used by financing activities	(179,206)	(3,532,713)
Decrease in cash and cash equivalents	(5,599,830)	(16,195,252)
Cash and cash equivalents at beginning of year	61,849,320	78,044,572
Cash and cash equivalents at end of year	$ 56,249,490	$ 61,849,320

Supplemental disclosure:
At September 30, 2019, amounts totaling $1,251,690 related to the purchase of property, plant and equipment were included in accounts payable and accrued expenses.

See accompanying notes.

1. Organization

CMC Healthcare System, Inc. (the System) is a not-for-profit organization formed effective July 1, 2001. The System functioned as the parent company and sole member of Catholic Medical Center (the Medical Center) (until December 31, 2016, as discussed below), Physician Practice Associates, Inc. (PPA), Alliance Enterprises, Inc. (Enterprises), Alliance Resources, Inc. (Resources), Alliance Ambulatory Services, Inc. (AAS), Alliance Health Services, Inc. (AHS), Doctors Medical Association, Inc. (DMA) and St. Peter's Home, Inc.

On December 30, 2016, the System became affiliated with Huggins Hospital (HH), a 25-bed critical access hospital in Wolfeboro, New Hampshire, and Monadnock Community Hospital (MCH), a 25-bed critical access hospital in Peterborough, New Hampshire, through the formation of a common parent, GraniteOne Health (GraniteOne). GraniteOne is a New Hampshire voluntary corporation that is recognized as being a Section 501(c)(3) tax-exempt and "supporting organization" within the meaning of Section 509(a)(3) of the Internal Revenue Code of 1986, as amended (the Code). GraniteOne serves as the sole member of HH and MCH and co-member of the Medical Center, along with the System. GraniteOne is governed by a thirteen member Board of Trustees appointed by each of the respective hospitals within the GraniteOne system. The GraniteOne Board of Trustees governs the GraniteOne system through the existence and execution of reserved powers to approve certain actions by the Boards of Trustees of each of the hospitals. Through GraniteOne, this more integrated healthcare system enhances the affiliated hospitals' ability to coordinate the delivery of patient care, implement best practices, eliminate inefficiencies and collaborate on regional planning. These efforts strengthen the hospitals' ability to meet the healthcare needs of their respective communities and provide for a more seamless patient experience across the continuum of care. The accompanying consolidated financial statements for the years ended September 30, 2019 and 2018 do not include the accounts and activity of GraniteOne, HH and MCH.

On September 30, 2019, GraniteOne, the Medical Center, the System, certain subsidiaries of the System, HH and MCH entered into a Combination Agreement (the Agreement) with Dartmouth-Hitchcock Health (D-HH) to combine GraniteOne and D-HH and its members into a more fully integrated healthcare delivery system. Pursuant to the terms of the Agreement, the parties intend to revise D-HH's corporate name to Dartmouth-Hitchcock Health GraniteOne (D-HH GO), which will continue to serve as the sole corporate member of the existing D-HH System Members (Mary Hitchcock Memorial Health and Dartmouth-Hitchcock Clinic, New London Hospital (NLH), Cheshire Medical Center (Cheshire), Mt. Ascutney Hospital and Health Center (MAHHC), Alice Peck Day Memorial Hospital (APD) and Visiting Nurse and Hospice for Vermont and New Hampshire (VNH)), and which will be substituted for GraniteOne as the sole corporate member of HH and MCH and as co-member, of the Medical Center and certain subsidiaries of the System (the Combination). The overarching goal of the Combination is to create a New Hampshire-based, integrated and regionally distributed health care delivery system that better serves its patients and communities. While the System will not be a component of the D-HH GO System, it will continue to serve as the corporate vehicle through which the Bishop of the Diocese of Manchester (the Bishop) ensures the Medical Center's adherence to the Ethical and Religious Directives for Catholic Health Care Services. Neither the System nor the Bishop will have authority over any other D-HH GO System Member, including HH and MCH. Subject to certain rights reserved to the Bishop and the System with respect to the Medical Center and the System's subsidiaries, D-HH GO will reserve to itself certain approval and initiation powers over the governance, financial, programmatic, administrative, and strategic decisions of D-HH GO System Members.

1. Organization (Continued)

On December 30, 2019, GraniteOne, the Medical Center, HH and MCH submitted a Joint Notice of Change of Control to the New Hampshire Attorney General, Director of Charitable Trusts pursuant to New Hampshire RSA 7:19-b beginning the regulatory review and approval process of the Combination. If all necessary approvals are obtained and closing conditions satisfied, D-HH GO will consist of a major academic medical center offering tertiary and quaternary services, an acute care community hospital in an urban setting (the Medical Center), an acute care community hospital in a rural setting (Cheshire), five rural critical access hospitals (NLH, MAHHC, APD, HH and MCH), a post-acute home health and hospice provider (VNH), and nearly 1,800 employed and affiliated primary and specialty care physicians. D-HH GO System Members will combine their resources to offer a broader array of inpatient, outpatient and ambulatory services.

2. Significant Accounting Policies

Basis of Presentation

The accompanying consolidated financial statements have been prepared using the accrual basis of accounting.

Principles of Consolidation

The consolidated financial statements include the accounts of the Medical Center, PPA, Enterprises, Resources, AAS, AHS, DMA and St. Peter's Home, Inc. Significant intercompany accounts and transactions have been eliminated in consolidation.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America (U.S. GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities as of the date of the financial statements. Estimates also affect the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates. The primary estimates relate to collectibility of receivables from patients and third-party payors, amounts payable to third-party payors, accrued compensation and benefits, conditional asset retirement obligations, and self-insurance reserves.

Income Taxes

The System and all related entities, with the exception of Enterprises and DMA, are not-for-profit corporations as described in Section 501(c)(3) of the Code and are exempt from federal income taxes on related income pursuant to Section 501(a) of the Code. Management evaluated the System's tax positions and concluded the System has maintained its tax-exempt status, does not have any significant unrelated business income and had taken no uncertain tax positions that require adjustment to the consolidated financial statements.

2. Significant Accounting Policies (Continued)

Enterprises and DMA are for-profit organizations and, in accordance with federal and state tax laws, file income tax returns, as applicable. There was no significant provision for income taxes for the years ended September 30, 2019 and 2018. There are no significant deferred tax assets or liabilities. These entities have concluded there are no significant uncertain tax positions requiring disclosure and there is no material liability for unrecognized tax benefits. It is the policy of these entities to recognize interest related to unrecognized tax benefits in interest expense and penalties in income tax expense.

Performance Indicator

(Deficiency) excess of revenues and gains over expenses is comprised of operating revenues and expenses and nonoperating gains and losses. For purposes of display, transactions deemed by management to be ongoing, major or central to the provision of health care services are reported as operating revenue and expenses. Peripheral or incidental transactions are reported as nonoperating gains or losses, which include contributions without donor restrictions, development costs, net investment income (including realized gains and losses on the sales of investments), net periodic pension costs (other than service cost), other nonoperating losses, and contributions to community agencies.

Charity Care

The System has a formal charity care policy under which patient care is provided to patients who meet certain criteria without charge or at amounts less than its established rates. The System does not pursue collection of amounts determined to qualify as charity care; therefore, they are not reported as revenues.

Of the System's $496,274,632 total expenses reported for the year ended September 30, 2019, an estimated $7,700,000 arose from providing services to charity patients. Of the System's $467,577,738 total expenses reported for the year ended September 30, 2018, an estimated $7,500,000 arose from providing services to charity patients. The estimated costs of providing charity services are based on a calculation which applies a ratio of costs to charges to the gross uncompensated charges associated with providing care to charity patients. The ratio of cost to charges is calculated based on the System's total expenses divided by gross patient service revenue.

Concentration of Credit Risk

Financial instruments which subject the System to credit risk consist primarily of cash equivalents, accounts receivable and investments. The risk with respect to cash equivalents is minimized by the System's policy of investing in financial instruments with short-term maturities issued by highly rated financial institutions. The System's accounts receivable are primarily due from third-party payors and amounts are presented net of expected contractual allowances and uncollectible amounts. The System's investment portfolio consists of diversified investments, which are subject to market risk. Investments that exceeded 10% of investments include the SSGA S&P 500 Tobacco Free Fund and the Dreyfus Treasury Securities Cash Management Fund as of September 30, 2019 and 2018.

2. Significant Accounting Policies (Continued)

Cash and Cash Equivalents

Cash and cash equivalents include certificates of deposit with maturities of three months or less when purchased and investments in overnight deposits at various banks. Cash and cash equivalents exclude amounts whose use is limited by board designation and amounts held by trustees under revenue bond and other agreements. The System maintains approximately $52,000,000 and $60,000,000 at September 30, 2019 and 2018, respectively, of its cash and cash equivalent accounts with a single institution. The System has not experienced any losses associated with deposits at this institution.

Net Patient Service Revenues and Accounts Receivable

The System has agreements with third-party payors that provide for payments at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, per diem payments and fee schedules. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the year the related services are rendered and adjusted in future years as final settlements are determined. Changes in these estimates are reflected in the consolidated financial statements in the year in which they occur.

The System recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered. For uninsured patients, the System provides a discount approximately equal to that of its largest private insurance payors.

The provision for doubtful accounts is based upon management's assessment of historical and expected net collections considering historical business and economic conditions, trends in health care coverage, and other collection indicators. The System records a provision for doubtful accounts in the year services are provided related to self-pay patients, including both uninsured patients and patients with deductible and copayment balances due for which third-party coverage exists for a portion of their balance.

Periodically, management assesses the adequacy of the allowance for doubtful accounts based upon historical write-off experience. The results of this review are then used to make any modifications to the provision for doubtful accounts to establish an appropriate allowance for doubtful accounts. Accounts receivable are written off after collection efforts have been followed in accordance with internal policies.

Inventories

Inventories of supplies are stated at the lower of cost (determined by the first-in, first-out method) or net realizable value.

2. Significant Accounting Policies (Continued)

Related Party Activity

The Medical Center has engaged in various transactions with GraniteOne, HH and MCH. The Medical Center recognized approximately $3.3 million and $3.4 million in revenue from these related parties for the years ended September 30, 2019 and 2018, respectively, which is reflected within other revenues in the accompanying consolidated statements of operations. The Medical Center also incurred expenses to these related parties of approximately $2.5 million and $399,000 for the years ended September 30, 2019 and 2018, respectively, of which $800,000 and $399,000, respectively, is reflected within operating expenses. Additionally, approximately $1.7 million as of September 30, 2019 is reflected within nonoperating gains (losses) in the accompanying consolidated statement of operations for the year ended September 30, 2019. As of September 30, 2019, the Medical Center had a net amount due from these related parties of approximately $2.6 million, of which $4.4 million is reflected within other current assets and $1.8 million is reflected within accounts payable and accrued expenses in the accompanying 2019 consolidated balance sheet. As of September 30, 2018, the Medical Center has a net amount due from these related parties of approximately $507,000, which is reflected within other current assets in the accompanying 2018 consolidated balance sheet.

Property, Plant and Equipment

Property, plant and equipment is stated at cost at time of purchase or fair value at the time of donation, less accumulated depreciation. The System's policy is to capitalize expenditures for major improvements and charge maintenance and repairs currently for expenditures which do not extend the lives of the related assets. The provisions for depreciation and amortization have been determined using the straight-line method at rates intended to amortize the cost of assets over their estimated useful lives, which range from 2 to 40 years. Assets which have been purchased but not yet placed in service are included in construction in progress and no depreciation expense is recorded.

Conditional Asset Retirement Obligations

The System recognizes the fair value of a liability for legal obligations associated with asset retirements in the year in which the obligation is incurred, in accordance with the Accounting Standards for *Accounting for Asset Retirement Obligations* (ASC 410-20). When the liability is initially recorded, the cost of the asset retirement obligation is capitalized by increasing the carrying amount of the related long lived asset. The liability is accreted to its present value each year, and the capitalized cost associated with the retirement obligation is depreciated over the useful life of the related asset. Upon settlement of the obligation, any difference between the cost to settle the asset retirement obligation and the liability recorded is recognized as a gain or loss in the consolidated statements of operations.

As of September 30, 2019 and 2018, $1,036,702 and $1,078,784, respectively, of conditional asset retirement obligations are included within accrued pension and other liabilities in the accompanying consolidated balance sheets.

2. Significant Accounting Policies (Continued)

Goodwill

The System reviews its goodwill and other long-lived assets annually to determine whether the carrying amount of such assets is impaired. Upon determination that an impairment has occurred, these assets are reduced to fair value. There were no impairments recorded for the years ended September 30, 2019 or 2018. The net carrying value of goodwill is $4,490,154 at September 30, 2019 and 2018 and is reflected within intangible assets and other in the accompanying consolidated balance sheets.

Retirement Benefits

The Catholic Medical Center Pension Plan (the Plan) provides retirement benefits for certain employees of the Medical Center and PPA who have attained age twenty-one and work at least 1,000 hours per year. The Plan consists of a benefit accrued to July 1, 1985, plus 2% of plan year earnings (to legislative maximums) per year. The System's funding policy is to contribute amounts to the Plan sufficient to meet minimum funding requirements set forth in the Employee Retirement Income Security Act of 1974, plus such additional amounts as may be determined to be appropriate from time to time. The Plan is intended to constitute a plan described in Section 414(k) of the Code, under which benefits derived from employer contributions are based on the separate account balances of participants in addition to the defined benefits under the Plan.

Effective January 1, 2008 the Medical Center decided to close participation in the Plan to new participants. As of January 1, 2008, current participants continued to participate in the Plan while new employees receive a higher matching contribution to the tax-sheltered annuity benefit program discussed below.

During 2011, the Board of Trustees voted to freeze the accrual of benefits under the Plan effective December 31, 2011.

The Plan was amended effective as of May 1, 2016 to provide a limited opportunity for certain terminated vested participants to elect an immediate lump sum or annuity distribution option.

The System also maintains tax-sheltered annuity benefit programs in which it matches one half of employee contributions up to 3% of their annual salary, depending on date of hire, plus an additional 3% - 5% based on tenure. The System made matching contributions under the program of $8,462,595 and $7,733,193 for the years ended September 30, 2019 and 2018, respectively.

During 2007, the Medical Center created a nonqualified deferred compensation plan covering certain employees under Section 457(b) of the Code. Under the plan, a participant may elect to defer a portion of their compensation to be held until payment in the future to the participant or his or her beneficiary. Consistent with the requirements of the Code, all amounts of deferred compensation, including but not limited to any investments held and all income attributable to such amounts, property, and rights will remain subject to the claims of the Medical Center's creditors, without being restricted to the payment of deferred compensation, until payment is made to the participant or their beneficiary. No contributions were made by the System for the years ended September 30, 2019 or 2018.

2. **Significant Accounting Policies (Continued)**

The System also provides a noncontributory supplemental executive retirement plan covering certain former executives of the Medical Center, as defined. The System's policy is to accrue costs under this plan using the "Projected Unit Credit Actuarial Cost Method" and to amortize past service costs over a fifteen year period. Benefits under this plan are based on the participant's final average salary, social security benefit, retirement income plan benefit, and total years of service. Certain investments have been designated for payment of benefits under this plan and are included in assets whose use is limited–pension and insurance obligations.

During 2007, the System created a supplemental executive retirement plan covering certain executives of the Medical Center under Section 457(f) of the Code. The System recorded compensation expense of $661,215 and $682,820 for the years ended September 30, 2019 and 2018, respectively, related to this plan.

Employee Fringe Benefits

The System has an "earned time" plan. Under this plan, each qualifying employee "earns" hours of paid leave for each pay period worked. These hours of paid leave may be used for vacations, holidays, or illness. Hours earned but not used are vested with the employee and are paid to the employee upon termination. The System expenses the cost of these benefits as they are earned by the employees.

Debt Issuance Costs/Original Issue Discount or Premium

The debt issuance costs incurred to obtain financing for the System's construction and renovation programs and refinancing of prior bonds and the original issue discount or premium are amortized to interest expense using the effective interest method over the repayment period of the bonds. The original issue discount or premium and debt issuance costs are presented as a component of long-term debt.

Assets Whose Use is Limited or Restricted

Assets whose use is limited or restricted include assets held by trustees under indenture agreements, pension and insurance obligations, designated assets set aside by the Board of Trustees, over which the Board retains control and may, at its discretion, subsequently use for other purposes, and donor-restricted investments.

Net Assets With Donor Restrictions

Gifts are reported as restricted support if they are received with donor stipulations that limit the use of donated assets. Donated investments, supplies and equipment are reported at fair value at the date of receipt. Unconditional promises to give cash and other assets are reported at fair value at the date of the receipt of the promise. When a donor restriction expires (when a stipulated time restriction ends or purpose restriction is accomplished), net assets with donor restrictions are reclassified as net assets without donor restrictions and reported in the statements of operations as either net assets released from restrictions (for noncapital related items) or as net assets released from restrictions used for capital purchases (capital related items). Some net assets with donor restrictions have been restricted by donors to be maintained by the System in perpetuity.

2. Significant Accounting Policies (Continued)

Except for contributions related to capital purchases, donor-restricted contributions whose restrictions are met within the same year as received are reported as contributions within net assets without donor restrictions in the accompanying consolidated financial statements.

Pledges Receivable

Pledges receivable are recognized as revenue when the unconditional promise to give is made. Pledges expected to be collected within one year are recorded at their net realizable value. Pledges that are expected to be collected in future years are recorded at the present value of estimated future cash flows. The present value of estimated future cash flows is measured utilizing risk-free rates of return adjusted for market and credit risk established at the time a contribution is received.

Investments and Investment Income

Investments are carried at fair value in the accompanying consolidated balance sheets. See Note 8 for further discussion regarding fair value measurements. Investment income (including realized gains and losses on investments and interest and dividends) is included in the (deficiency) excess of revenues and gains over expenses unless the income is restricted by donor or law, in which case it is reported as an increase or decrease in net assets with donor restrictions. Realized gains or losses on the sale of investment securities are determined by the specific identification method and are recorded on the settlement date. Unrealized gains and losses on investments are excluded from the (deficiency) excess of revenues and gains over expenses unless the investments are classified as trading securities or losses are considered other-than-temporary.

Derivative Instruments

Derivatives are recognized as either assets or liabilities in the consolidated balance sheets at fair value regardless of the purpose or intent for holding the instrument. Changes in the fair value of derivatives are recognized either in the (deficiency) excess of revenues and gains over expenses or net assets, depending on whether the derivative is speculative or being used to hedge changes in fair value or cash flows. See also Note 6.

Beneficial Interest in Perpetual Trust

The System is the beneficiary of trust funds administered by trustees or other third parties. Trusts wherein the System has the irrevocable right to receive the income earned on the trust assets in perpetuity are recorded as net assets with donor restrictions at the fair value of the trust at the date of receipt. Income distributions from the trusts are reported as investment income that increase net assets without donor restrictions, unless restricted by the donor. Annual changes in the fair value of the trusts are recorded as increases or decreases to net assets with donor restrictions.

2. Significant Accounting Policies (Continued)

Endowment, Investment and Spending Policies

In accordance with the *Uniform Prudent Management of Institutional Funds Act* (UPMIFA), the System considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: (a) the duration and preservation of the fund; (b) the purpose of the organization and the donor-restricted endowment fund; (c) general economic conditions; (d) the possible effect of inflation and deflation; (e) the expected total return from income and the appreciation of investments; (f) other resources of the organization; and (g) the investment policies of the organization.

Spending policies may be adopted by the System, from time to time, to provide a stream of funding for the support of key programs. The spending policies are structured in a manner to ensure that the purchasing power of the assets is maintained while providing the desired level of annual funding to the programs. The System currently has a policy allowing interest and dividend income earned on investments to be used for operations with the goal of keeping principal, including its appreciation, intact.

The System's investment policies provide guidance for the prudent and skillful management of invested assets with the objective of preserving capital and maximizing returns. The invested assets include endowment, specific purpose and board designated funds.

Endowment funds are identified as perpetual in nature, intended to provide support for current or future operations and other purposes identified by the donor. These funds are managed with disciplined longer-term investment objectives and strategies designed to accommodate relevant, reasonable, or probable events.

Specific purpose funds are temporary in nature, restricted as to time or purpose as identified by the donor or grantor. These funds have various intermediate/long-term time horizons associated with specific identified spending objectives.

Board designated funds have various intermediate/long-term time horizons associated with specific spending objectives as determined by the Board of Trustees.

Management of these assets is designed to maximize total return while preserving the capital values of the funds, protecting the funds from inflation and providing liquidity as needed. The objective is to provide a real rate of return that meets inflation, plus 4% to 5%, over a long-term time horizon.

The System targets a diversified asset allocation that places emphasis on achieving its long-term return objectives within prudent risk constraints.

Federal Grant Revenue and Expenditures

Revenues and expenses under federal grant programs are recognized as the related expenditure is incurred.

2. Significant Accounting Policies (Continued)

Malpractice Loss Contingencies

The System has a claims-made basis policy for its malpractice insurance coverage. A claims-made basis policy provides specific coverage for claims reported during the policy term. The System has established a reserve to cover professional liability exposure, which may not be covered by insurance. The possibility exists, as a normal risk of doing business, that malpractice claims in excess of insurance coverage may be asserted against the System. In the event a loss contingency should occur, the System would give it appropriate recognition in its consolidated financial statements in conformity with accounting standards. The System expects to be able to obtain renewal or other coverage in future years.

In accordance with Accounting Standards Update (ASU) No. 2010-24, "*Health Care Entities*" (Topic 954): *Presentation of Insurance Claims and Related Insurance Recoveries*, at September 30, 2019 and 2018, the System recorded a liability of $13,252,269 and $12,520,618, respectively, related to estimated professional liability losses covered under this policy. At September 30, 2019 and 2018, the System also recorded a receivable of $9,584,019 and $8,829,118, respectively, related to estimated recoveries under insurance coverage for recoveries of the potential losses. These amounts are included in accrued pension and other liabilities, and intangible assets and other, respectively, on the consolidated balance sheets.

Workers' Compensation

The System maintains workers' compensation insurance under a self-insured plan. The plan offers, among other provisions, certain specific and aggregate stop-loss coverage to protect the System against excessive losses. The System has employed independent actuaries to estimate the ultimate costs, if any, of the settlement of such claims. Accrued workers' compensation losses of $3,069,898 and $3,061,261 at September 30, 2019 and 2018, respectively, have been discounted at 1.25% and, in management's opinion, provide an adequate reserve for loss contingencies. At September 30, 2019, $1,397,510 and $1,672,388 is recorded within accounts payable and accrued expenses and accrued pension and other liabilities, respectively, in the accompanying consolidated balance sheets. The System has also recorded $258,107 and $408,034 within other current assets and intangible assets and other, respectively, in the accompanying consolidated balance sheets to limit the accrued losses to the retention amount at September 30, 2019. At September 30, 2018, $1,359,646 and $1,701,615 is recorded within accounts payable and accrued expenses and accrued pension and other liabilities, respectively, in the accompanying consolidated balance sheets. The System has also recorded $248,403 and $408,513 within other current assets and intangible assets and other, respectively, in the accompanying consolidated balance sheets to limit the accrued losses to the retention amount at September 30, 2018.

Health Insurance

The System has a self-funded health insurance plan. The plan is administered by an insurance company and the System has employed independent actuaries to estimate unpaid claims, and those claims incurred but not reported at fiscal year end. The System was insured above a stop-loss amount of $570,000 and $375,000 at September 30, 2019 and 2018, respectively, on individual claims. Estimated unpaid claims, and those claims incurred but not reported, at September 30, 2019 and 2018 of $2,334,000 and $2,849,427, respectively, are reflected in the accompanying consolidated balance sheets within accounts payable and accrued expenses.

2. Significant Accounting Policies (Continued)

Functional Expense Allocation

The costs of providing program services and other activities have been summarized on a functional basis in Note 11. Accordingly, costs have been allocated among program services and supporting services benefitted.

Advertising Costs

The System expenses advertising costs as incurred, and such costs totaled approximately $1,298,000 and $1,918,000 for the years ended September 30, 2019 and 2018, respectively.

Recent Accounting Pronouncements

In August 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2016-14, *Not-for-Profit Entities (Topic 958)* (ASU 2016-14) – *Presentation of Financial Statements of Not-for-Profit Entities.* The update addresses the complexity and understandability of net asset classification, deficiencies in information about liquidity and availability of resources, and the lack of consistency in the type of information provided about expenses and investment return. ASU 2016-14 is effective for the System for the year ended September 30, 2019. The System has adjusted the presentation of these consolidated financial statements and related disclosures accordingly. ASU 2016-14 has been applied retrospectively to all periods presented. The adoption of ASU 2016-14 had no impact to changes in net assets or total net assets in 2019 or 2018.

In May 2014, the FASB issued ASU No. 2014-09, *Revenue from Contracts with Customers* (ASU 2014-09), which requires revenue to be recognized when promised goods or services are transferred to customers in amounts that reflect the consideration to which the System expects to be entitled in exchange for those goods and services. ASU 2014-09 will replace most existing revenue recognition guidance in U.S. GAAP when it becomes effective. ASU 2014-09 is effective for the System on October 1, 2019. ASU 2014-09 permits the use of either the retrospective or cumulative effect transition method. The System is evaluating the impact that ASU 2014-09 will have on its revenue recognition policies, but does not expect the new pronouncement will have a material impact on its consolidated financial statements.

In January 2016, the FASB issued ASU No. 2016-01, *Financial Instruments – Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities* (ASU 2016-01). The amendments in ASU 2016-01 address certain aspects of recognition, measurement, presentation and disclosure of financial instruments. ASU 2016-01 is effective for the System for the year ended September 30, 2020, with early adoption permitted. The System is currently evaluating the impact that ASU 2016-01 will have on its consolidated financial statements.

2. Significant Accounting Policies (Continued)

In February 2016, the FASB issued ASU No. 2016-02, *Leases (Topic 842)* (ASU 2016-02). Under ASU 2016-02, at the commencement of a long-term lease, lessees will recognize a liability equivalent to the discounted payments due under the lease agreement, as well as an offsetting right-of-use asset. ASU 2016-02 is effective for the System on October 1, 2021, with early adoption permitted. Lessees (for capital and operating leases) must apply a modified retrospective transition approach for leases existing at, or entered into after, the beginning of the earliest comparative period presented in the consolidated financial statements. The modified retrospective approach would not require any transition accounting for leases that expired before the earliest comparative period presented. Lessees may not apply a full retrospective transition approach. The System is currently evaluating the impact of the pending adoption of ASU 2016-02 on the System's consolidated financial statements.

In November 2016, the FASB issued ASU No. 2016-18, *Statement of Cash Flows (Topic 230): Restricted Cash (a consensus of the FASB Emerging Issues Task Force)* (ASU 2016-18), which provides guidance on the presentation of restricted cash or restricted cash equivalents in the statement of cash flows. ASU 2016-18 will be effective for the System's fiscal year ended September 30, 2020, and early adoption is permitted. ASU 2016-18 must be applied using a retrospective transition method. The System is currently evaluating the impact of the adoption of this guidance on its consolidated financial statements.

In June 2018, the FASB issued ASU No. 2018-08, *Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made* (ASU 2018-08). Due to diversity in practice, ASU 2018-08 clarifies the definition of an exchange transaction as well as the criteria for evaluating whether contributions are unconditional or conditional. ASU 2018-08 is effective for the System on October 1, 2019, with early adoption permitted. The System is currently evaluating the impact that ASU 2018-08 will have on its consolidated financial statements.

In August 2018, the FASB issued ASU 2018-13, *Fair Value Measurement (Topic 820): Disclosure Framework – Changes to the Disclosure Requirements for Fair Value Measurement* (ASU 2018-13). The amendments in this ASU modify the disclosure requirements for fair value measurements for Level 3 assets and liabilities, and eliminate the requirement to disclose transfers between Levels 1 and 2 of the fair value hierarchy, among other modifications. ASU 2018-13 is effective for the System on October 1, 2020, with early adoption permitted. The System is currently evaluating the impact that ASU 2018-13 will have on its consolidated financial statements.

Subsequent Events

Management of the System evaluated events occurring between the end of the System's fiscal year and February 4, 2020, the date the consolidated financial statements were available to be issued.

3. Financial Assets and Liquidity Resources

Financial assets and liquidity resources available within one year for general expenditure, such as operating expenses, scheduled principal payments on debt, and capital construction costs, consisted of the following at September 30, 2019:

Cash and cash equivalents	$ 56,249,490
Short-term investments	4,021,270
Accounts receivable	79,322,642
	$139,593,402

To manage liquidity, the System maintains sufficient cash and cash equivalent balances to support daily operations throughout the year. Cash and cash equivalents include bank deposits, money market funds, and other similar vehicles that generate a return on cash and provide daily liquidity to the System. In addition, the System has board-designated assets that can be utilized at the discretion of management to help fund both operational needs and/or capital projects. As of September 30, 2019, the balance in board-designated assets was approximately $110 million.

4. Net Patient Service Revenue

The following summarizes net patient service revenue for the years ended September 30:

	2019	2018
Gross patient service revenue	$1,435,238,995	$1,341,051,947
Less contractual allowances	(969,481,433)	(888,541,572)
Less provision for doubtful accounts	(21,644,644)	(20,334,249)
Net patient service revenue	$ 444,112,918	$ 432,176,126

The System maintains contracts with the Social Security Administration ("Medicare") and the State of New Hampshire Department of Health and Human Services ("Medicaid"). The System is paid a prospectively determined fixed price for each Medicare and Medicaid inpatient acute care service depending on the type of illness or the patient's diagnosis related group classification. Capital costs and certain Medicare and Medicaid outpatient services are also reimbursed on a prospectively determined fixed price. The System receives payment for other Medicaid outpatient services on a reasonable cost basis which are settled with retroactive adjustments upon completion and audit of related cost finding reports.

Differences between amounts previously estimated and amounts subsequently determined to be recoverable or payable are included in net patient service revenues in the year that such amounts become known. The percentage of net patient service revenues earned from the Medicare and Medicaid programs was 37% and 5%, respectively, for the year ended September 30, 2019 and 39% and 5%, respectively, for the year ended September 30, 2018.

4. Net Patient Service Revenue (Continued)

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The System believes that it is in compliance with all applicable laws and regulations; compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs (Note 15).

The System also maintains contracts with certain commercial carriers, health maintenance organizations, preferred provider organizations and state and federal agencies. The basis for payment under these agreements includes prospectively determined rates per discharge and per day, discounts from established charges and fee screens. The System does not currently hold reimbursement contracts which contain financial risk components.

The approximate percentages of patient service revenues, net of contractual allowances and discounts and provision for doubtful accounts for the years ended September 30 from third-party payors and uninsured patients are as follows:

	Third-Party Payors	Uninsured Patients	Total All Payors
2019			
Net patient service revenues, net of contractual allowance and discounts	99.4%	0.6%	100.0%
2018			
Net patient service revenues, net of contractual allowance and discounts	99.6%	0.4%	100.0%

An estimated breakdown of patient service revenues, net of contractual allowances, discounts and provision for doubtful accounts recognized for the years ended September 30 from major payor sources, is as follows:

	Gross Patient Service Revenues	Contractual Allowances and Discounts	Provision for Doubtful Accounts	Net Patient Service Revenues Less Provision for Doubtful Accounts
2019				
Private payors (includes coinsurance and deductibles)	$ 524,868,968	$(264,786,990)	$ (7,676,695)	$ 252,405,283
Medicaid	151,316,824	(128,250,350)	(332,821)	22,733,653
Medicare	725,090,044	(555,260,823)	(3,439,271)	166,389,950
Self-pay	33,963,159	(21,183,270)	(10,195,857)	2,584,032
	$1,435,238,995	$(969,481,433)	$(21,644,644)	$ 444,112,918

4. Net Patient Service Revenue (Continued)

	Gross Patient Service Revenues	Contractual Allowances and Discounts	Provision for Doubtful Accounts	Net Patient Service Revenues Less Provision for Doubtful Accounts
2018				
Private payors (includes coinsurance and deductibles)	$ 477,457,407	$(229,413,775)	$ (9,298,563)	$ 238,745,069
Medicaid	137,508,097	(113,364,379)	(651,292)	23,492,426
Medicare	695,141,198	(523,976,071)	(3,140,980)	168,024,147
Self-pay	30,945,245	(21,787,347)	(7,243,414)	1,914,484
	$1,341,051,947	$(888,541,572)	$(20,334,249)	$ 432,176,126

The System recognizes changes in accounting estimates for net patient service revenues and third-party payor settlements as new events occur or as additional information is obtained. For the year ended September 30, 2019, there were no significant adjustments recorded for changes to prior year estimates. For the year ended September 30, 2018, favorable adjustments recorded for changes to prior year estimates were approximately $1,000,000.

Medicaid Enhancement Tax and Disproportionate Share Payment

Under the State of New Hampshire's (the State) tax code, the State imposes a Medicaid Enhancement Tax (MET) equal to 5.40% of the Medical Center's net patient service revenues with certain exclusions. The amount of tax incurred by the Medical Center for the years ended September 30, 2019 and 2018 was $21,382,132 and $19,968,497, respectively.

In the fall of 2010, in order to remain in compliance with stated federal regulations, the State of New Hampshire adopted a new approach related to Medicaid disproportionate share funding (DSH) retroactive to July 1, 2010. Unlike the former funding method, the State's approach led to a payment that was not directly based on, and did not equate to, the level of tax imposed. As a result, the legislation created some level of losses at certain New Hampshire hospitals, while other hospitals realized gains. DSH payments from the State are recorded in operating revenues and amounted to $22,566,094 and $17,993,289 for the years ended September 30, 2019 and 2018, respectively, net of reserves referenced below.

The Centers for Medicare and Medicaid Services (CMS) has completed audits of the State's program and the disproportionate share payments made by the State from 2011 through 2014, the first years that those payments reflected the amount of uncompensated care provided by New Hampshire hospitals. It is possible that subsequent years will also be audited by CMS. The System has recorded reserves to address its potential exposure based on the audit results to date or any future redistributions. During 2019, the System reduced the recorded reserves by approximately $4,300,000.

5. Property, Plant and Equipment

The major categories of property, plant and equipment are as follows at September 30:

	Useful Lives	2019	2018
Land and land improvements	2-40 years	$ 4,246,500	$ 3,630,354
Buildings and improvements	2-40 years	137,678,182	128,776,786
Fixed equipment	3-25 years	47,021,894	46,562,689
Movable equipment	3-25 years	154,415,222	138,314,958
Construction in progress		8,565,604	9,269,135
		351,927,402	326,553,922
Less accumulated depreciation and amortization		(208,816,039)	(191,956,028)
Net property, plant and equipment		$ 143,111,363	$ 134,597,894

Depreciation expense amounted to $16,860,011 and $16,092,263 for the years ended September 30, 2019 and 2018, respectively.

The cost of equipment under capital leases was $7,844,527 at September 30, 2019 and 2018. Accumulated amortization of the leased equipment at September 30, 2019 and 2018 was $7,691,462 and $7,059,231, respectively. Amortization of assets under capital leases is included in depreciation and amortization expense.

6. Long-Term Debt and Notes Payable

Long-term debt consists of the following at September 30:

	2019	2018
New Hampshire Health and Education Facilities Authority (the Authority) Revenue Bonds:		
Series 2012 Bonds with interest ranging from 4.00% to 5.00% per year and principal payable in annual installments ranging from $1,125,000 to $2,755,000 through July 2032	$ 19,800,000	$ 22,450,000
Series 2015A Bonds with interest at a fixed rate of 2.27% per year and principal payable in annual installments ranging from $185,000 to $1,655,000 through July 2040	21,650,000	22,255,000
Series 2015B with variable interest subject to interest rate swap described below and principal payable in annual installments ranging from $195,000 to $665,000 through July 2036	8,060,000	8,260,000

6. Long-Term Debt and Notes Payable (Continued)

	2019	2018
New Hampshire Health and Education Facilities Authority (the Authority) Revenue Bonds (Continued):		
Series 2017 Bonds with interest ranging from 3.38% to 5.00% per year and principal payable in annual installments ranging from $2,900,000 to $7,545,000 beginning in July 2033 through July 2044	$ 61,115,000	$ 61,115,000
	110,625,000	114,080,000
Construction loan – see below	3,513,632	–
MOB LLC note payable – see below	7,798,500	8,032,500
Capitalized lease obligations	344,079	1,020,278
Unamortized original issue premiums/discounts	5,057,437	5,450,325
Unamortized debt issuance costs	(1,296,818)	(1,304,187)
	126,041,830	127,278,916
Less current portion	(4,158,079)	(4,365,199)
	$121,883,751	$122,913,717

The Authority Revenue Bonds

In December 2012, the Medical Center, in connection with the Authority, issued $35,275,000 of tax-exempt fixed rate revenue bonds (Series 2012). Under the terms of the loan agreements, the Medical Center has granted the Authority a first collateralized interest in all gross receipts and a mortgage lien on existing and future property, plant and equipment. The Medical Center is required to maintain a minimum debt service coverage ratio of 1.20. The Medical Center was in compliance with this covenant as of September 30, 2019. The proceeds of the Series 2012 bond issue were used to advance refund the remaining 2002A Bonds, advance refund certain 2002B Bonds, pay off a short term CAN note and fund certain capital purchases.

On September 3, 2015, the Authority issued $32,720,000 of Revenue Bonds, Catholic Medical Center Issue, Series 2015, consisting of the $24,070,000 aggregate principal amount Series 2015A Bonds and the $8,650,000 aggregate principal amount Series 2015B Bonds sold via direct placement to a financial institution. Although the Series 2015B Bonds were issued, they were not drawn on until July 1, 2016, as discussed below. Under the terms of the loan agreements, the Medical Center has granted the Authority a first collateralized interest in all gross receipts and a mortgage lien on existing and future property, plant and equipment. The Medical Center is required to maintain a minimum debt service coverage ratio of 1.20. The Medical Center was in compliance with this covenant as of September 30, 2019.

The Series 2015A Bonds were issued to provide funds for the purpose of (i) advance refunding a portion of the outstanding 2006 Bonds in an amount of $20,655,000 to the first call date of July 1, 2016, (ii) funding certain construction projects and equipment purchases in an amount of approximately $3,824,000, and (iii) paying the costs of issuance related to the Series 2015 Bonds.

6. Long-Term Debt and Notes Payable (Continued)

The Series 2015B Bonds were structured as drawdown bonds. On July 1, 2016, the full amount available under the Series 2015B Bonds totaling $8,650,000 was drawn upon and the proceeds in combination with cash contributed by the Medical Center totaling $555,000 were used to currently refund the remaining balance of the Series 2006 Bonds totaling $9,205,000.

On September 1, 2017, the Authority issued $61,115,000 of Revenue Bonds, Catholic Medical Center Issue, Series 2017. The Series 2017 Bonds were issued to fund various construction projects and equipment purchases, as well as pay certain costs of issuance related to the Series 2017 Bonds. Under the terms of the loan agreements, the Medical Center has granted the Authority a first collateralized interest in all gross receipts and a mortgage lien on existing and future property, plant and equipment. The Medical Center is required to maintain a minimum debt service coverage ratio of 1.20. The Medical Center was in compliance with this covenant as of September 30, 2019.

The Medical Center has an agreement with the Authority, which provides for the establishment of various funds, the use of which is generally restricted to the payment of debt, as well as a construction fund related to the Series 2017 Bonds. These funds are administered by a trustee, and income earned on certain of these funds is similarly restricted.

Construction Loan

On July 1, 2019, the Medical Center established a nonrevolving line of credit up to $10,000,000 with a bank in order to fund the expansion of the Medical Center as discussed in Note 15. The line of credit bears interest at the LIBOR lending rate plus 0.75% (2.84% at September 30, 2019). Advances from the line of credit are available through July 1, 2021, at which time the then outstanding line of credit balance will automatically convert to a term loan. Upon conversion, the Medical Center shall make monthly payments of principal and interest, assuming a 30-year level monthly principal and interest payment schedule, with a final maturity of July 1, 2029. The bank shall compute the schedule of principal payments based on the interest rate applicable on the conversion date. Payments of interest only are due on a monthly basis until the conversion date. The Medical Center has pledged gross receipts as collateral and is also required to maintain a minimum debt service coverage ratio of 1.20. The Medical Center was in compliance with this covenant as of September 30, 2019. As of September 30, 2019, the Medical Center has drawn $3,513,632 on this line of credit.

MOB LLC Notes Payable

During 2007, MOB LLC (a subsidiary of Enterprises) established a nonrevolving line of credit for $9,350,000 with a bank in order to fund construction of a medical office building. The line of credit bore interest at the LIBOR lending rate plus 1%. Payments of interest only were due on a monthly basis until the completed construction of the medical office. During 2008, the building construction was completed and the line of credit was converted to a note payable with payments of interest (at the one-month LIBOR rate plus 1.4%) and principal due on a monthly basis, with all payments to be made no later than April 1, 2018.

6. Long-Term Debt and Notes Payable (Continued)

On March 27, 2018, the MOB LLC note payable discussed above was refinanced to a term loan totaling $8,130,000. Interest is fixed at 3.71% and is payable monthly. Principal payments of $19,500 are due in monthly installments beginning May 1, 2018, and continuing until March 27, 2028, at which time the remaining unpaid principal and interest shall be due in full. Under the terms of the loan agreement, the Medical Center and MOB LLC (the Obligated Group) has granted the bank a first collateralized interest in all gross receipts and a mortgage lien on existing and future property, plant and equipment. The Medical Center and the System also guarantee the note payable. The Obligated Group is required to maintain a minimum debt service coverage ratio of 1.20. The Obligated Group was in compliance with this covenant as of September 30, 2019.

The aggregate principal payments due on the revenue bonds, capital lease obligations and other debt obligations for each of the five years ending September 30 and thereafter are as follows:

2020	$ 4,158,079
2021	2,650,886
2022	2,779,704
2023	3,001,881
2024	3,094,120
Thereafter	106,596,541
	$122,281,211

Interest paid by the System totaled $4,688,512 (including capitalized interest of $158,155) for the year ended September 30, 2019 and $4,351,405 (including capitalized interest of $251,490) for the year ended September 30, 2018.

The fair value of the System's long-term debt is estimated using discounted cash flow analysis, based on the System's current incremental borrowing rate for similar types of borrowing arrangements. The fair value of the System's long-term debt, excluding capitalized lease obligations, was approximately $128,000,000 and $122,000,000 at September 30, 2019 and 2018, respectively.

Derivatives

The System uses derivative financial instruments principally to manage interest rate risk. During 2007, MOB LLC entered into an interest rate swap agreement with an initial notional amount of $9,350,000 in connection with its line of credit. Under this agreement, MOB LLC paid a fixed rate equal to 5.21%, and received a variable rate of the one-month LIBOR rate. The interest rate swap agreement terminated April 1, 2018. The change in fair value of this interest swap agreement totaled $184,767 during 2018, which amount was included within nonoperating investment income within the 2018 consolidated statements of operations.

6. Long-Term Debt and Notes Payable (Continued)

In January 2016, the Medical Center entered into an interest rate swap agreement with an initial notional amount of $8,650,000 in connection with its Series 2015B Bond issuance. The swap agreement hedges the Medical Center's interest exposure by effectively converting interest payments from variable rates to a fixed rate. The swap agreement is designated as a cash flow hedge of the underlying variable rate interest payments, and changes in the fair value of the swap agreement are reported as a change in net assets without donor restrictions. Under this agreement, the Medical Center pays a fixed rate equal to 1.482%, and receives a variable rate of 69.75% of the one-month LIBOR rate (1.46% at September 30, 2019). Payments under the swap agreement began August 1, 2016 and the agreement will terminate August 1, 2025.

The fair value of the Medical Center's interest rate swap agreement amounted to a liability of $220,010 as of September 30, 2019, which amount has been recorded within accrued pension and other liabilities in the accompanying consolidated balance sheets. The fair value of the Medical Center's interest rate swap agreement amounted to an asset of $262,725 as of September 30, 2018, which amount has been recorded within intangible assets and other in the accompanying consolidated balance sheets. The (decrease) increase in the fair value of this derivative of $(482,735) and $302,826, respectively, has been included within the consolidated statements of changes in net assets as a change in net assets without donor restrictions for the years ended September 30, 2019 and 2018.

7. Operating Leases

The System has various noncancelable agreements to lease various pieces of medical equipment. The System also has noncancelable leases for office space and its physician practices. Rental expense under all leases for the years ended September 30, 2019 and 2018 was $4,847,292 and $4,857,031, respectively.

Estimated future minimum lease payments under noncancelable operating leases are as follows:

2020	$ 3,180,427
2021	3,151,760
2022	3,178,564
2023	3,155,635
2024	3,048,854
Thereafter	5,620,891
	$21,336,131

8. Investments and Assets Whose Use is Limited

Investments and assets whose use is limited are comprised of the following at September 30:

	2019		2018	
	Fair Value	Cost	Fair Value	Cost
Cash and cash equivalents	$ 16,988,051	$ 16,988,051	$ 16,525,946	$ 16,525,946
U.S. federal treasury obligations	19,045,894	19,043,708	36,950,913	36,957,749
Marketable equity securities	44,292,283	41,130,117	44,031,227	39,959,906
Fixed income securities	38,160,610	38,096,345	57,757,424	58,911,509
Private investment funds	51,796,283	21,653,351	55,530,346	25,886,418
Pledges receivable	758,184	758,184	–	–
	$171,041,305	$137,669,756	$210,795,856	$178,241,528

Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability (an exit price) in the principal or most advantageous market for the asset or liability in an orderly transaction between market participants on the measurement date. In determining fair value, the use of various valuation approaches, including market, income and cost approaches, is permitted.

A fair value hierarchy has been established based on whether the inputs to valuation techniques are observable or unobservable. Observable inputs reflect market data obtained from sources independent of the reporting entity and unobservable inputs reflect the entity's own assumptions about how market participants would value an asset or liability based on the best information available. Valuation techniques used to measure fair value must maximize the use of observable inputs and minimize the use of unobservable inputs. The standard describes a fair value hierarchy based on three levels of inputs, of which the first two are considered observable and the last unobservable, that may be used to measure fair value.

The following describes the hierarchy of inputs used to measure fair value and the primary valuation methodologies used by the System for financial instruments measured at fair value on a recurring basis. The three levels of inputs are as follows:

Level 1 — Observable inputs such as quoted prices in active markets;

Level 2 — Inputs, other than the quoted prices in active markets, that are observable either directly or indirectly; and

Level 3 — Unobservable inputs in which there is little or no market data.

8. Investments and Assets Whose Use is Limited (Continued)

Assets and liabilities measured at fair value are based on one or more of three valuation techniques. The three valuation techniques are as follows:

- *Market approach* – Prices and other relevant information generated by market transactions involving identical or comparable assets or liabilities;
- *Cost approach* – Amount that would be required to replace the service capacity of an asset (i.e., replacement cost); and
- *Income approach* – Techniques to convert future amounts to a single present amount based on market expectations (including present value techniques).

In determining the appropriate levels, the System performs a detailed analysis of the assets and liabilities. There have been no changes in the methodologies used at September 30, 2019 and 2018.

The following is a description of the valuation methodologies used:

U.S. Federal Treasury Obligations and Fixed Income Securities

The fair value is determined by using broker or dealer quotations, external pricing providers, or alternative pricing sources with reasonable levels of price transparency. The System holds fixed income mutual funds and exchange traded funds, governmental and federal agency debt instruments, municipal bonds, corporate bonds, and foreign bonds which are primarily classified as Level 1 within the fair value hierarchy.

Marketable Equity Securities

Marketable equity securities are valued based on stated market prices and at the net asset value of shares held by the System at year end, which generally results in classification as Level 1 within the fair value hierarchy.

Private Investment Funds

The System invests in private investment funds that consist primarily of limited partnership interests in investment funds, which, in turn, invest in diversified portfolios predominantly comprised of equity and fixed income securities, as well as options, futures contracts, and some other less liquid investments. Management has approved procedures pursuant to the methods in which the System values these investments, which ordinarily will be the amount equal to the pro-rata interest in the net assets of the limited partnership, as such value is supplied by, or on behalf of, each investment manager from time to time, usually monthly and/or quarterly.

8. Investments and Assets Whose Use is Limited (Continued)

System management is responsible for the fair value measurements of investments reported in the consolidated financial statements. Such amounts are generally determined using audited financial statements of the funds and/or recently settled transactions. Because of inherent uncertainty of valuation of certain private investment funds, the estimate of the fund manager or general partner may differ from actual values, and differences could be significant. Management believes that reported fair values of its private investment funds at the consolidated balance sheet dates are reasonable.

Fair Value on a Recurring Basis

The following table presents information about the System's assets and liabilities measured at fair value on a recurring basis based upon the lowest level of significant input to the valuations at September 30:

2019	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 16,988,051	$ –	$ –	$ 16,988,051
U.S. federated treasury obligations	19,045,894	–	–	19,045,894
Marketable equity securities	44,292,283	–	–	44,292,283
Fixed income securities	38,160,610	–	–	38,160,610
Pledges receivable	–	–	758,184	758,184
	$118,486,838	$ –	$758,184	119,245,022
Investments measured at net asset value:				
Private investment funds				51,796,283
Total assets at fair value				$171,041,305
Liabilities				
Interest rate swap agreement	$ –	$ –	$220,010	$ 220,010
2018				
Assets				
Cash and cash equivalents	$ 16,525,946	$ –	$ –	$ 16,525,946
U.S. federated treasury obligations	36,950,913	–	–	36,950,913
Marketable equity securities	44,031,227	–	–	44,031,227
Fixed income securities	57,757,424	–	–	57,757,424
Interest rate swap agreement	–	–	262,725	262,725
	$155,265,510	$ –	$262,725	155,528,235
Investments measured at net asset value:				
Private investment funds				55,530,346
Total assets at fair value				$211,058,581

8. Investments and Assets Whose Use is Limited (Continued)

The following table presents the assets (liabilities) carried at fair value as of September 30, 2019 and 2018 that are classified within Level 3 of the fair value hierarchy.

	Pledges Receivable
Balance at September 30, 2018	$ –
Net activity	758,184
Balance at September 30, 2019	$758,184

	Interest Rate Swap Agreement
Balance at September 30, 2017	$(224,868)
Unrealized gains	487,593
Balance at September 30, 2018	262,725
Unrealized losses	(482,735)
Balance at September 30, 2019	$(220,010)

There were no significant transfers between Levels 1, 2 or 3 for the years ended September 30, 2019 or 2018.

Net Asset Value Per Share

The following table discloses the fair value and redemption frequency of those assets whose fair value is estimated using the net asset value per share practical expedient at September 30:

Category	Fair Value	Unfunded Commitments	Redemption Frequency	Notice Period
2019				
Private investment funds	$48,155,175	$ –	Daily/monthly	2-30 day notice
Private investment funds	3,641,108	–	Quarterly	30 day notice
2018				
Private investment funds	$52,108,790	$ –	Daily/monthly	2-30 day notice
Private investment funds	3,421,556	–	Quarterly	30 day notice

8. Investments and Assets Whose Use is Limited (Continued)

Investment Strategies

U.S. Federal Treasury Obligations and Fixed Income Securities

The primary purpose of these investments is to provide a highly predictable and dependable source of income, preserve capital, reduce the volatility of the total portfolio, and hedge against the risk of deflation or protracted economic contraction.

Marketable Equity Securities

The primary purpose of equity investments is to provide appreciation of principal and growth of income with the recognition that this requires the assumption of greater market volatility and risk of loss. The total equity portion of the portfolio will be broadly diversified according to economic sector, industry, number of holdings and other characteristics, including style and capitalization. The System may employ multiple equity investment managers, each of whom may have distinct investment styles. Accordingly, while each manager's portfolio may not be fully diversified, it is expected that the combined equity portfolio will be broadly diversified.

Private Investment Funds

The primary purpose of private investment funds is to provide further portfolio diversification and to reduce overall portfolio volatility by investing in strategies that are less correlated with traditional equity and fixed income investments. Private investment funds may provide access to strategies otherwise not accessible through traditional equities and fixed income such as derivative instruments, real estate, distressed debt and private equity and debt.

Fair Value of Other Financial Instruments

Other financial instruments consist of accounts receivable, accounts payable and accrued expenses, amounts payable to third-party payors and long-term debt. The fair value of all financial instruments other than long-term debt approximates their relative book values as these financial instruments have short-term maturities or are recorded at amounts that approximate fair value. See Note 6 for disclosure of the fair value of long-term debt.

9. Retirement Benefits

A reconciliation of the changes in the Catholic Medical Center Pension Plan, the Medical Center's Supplemental Executive Retirement Plan and the New Hampshire Medical Laboratories Retirement Income Plan projected benefit obligations and the fair value of assets for the years ended September 30, 2019 and 2018, and a statement of funded status of the plans for both years is as follows:

	Catholic Medical Center Pension Plan		Pre-1987 Supplemental Executive Retirement Plan		New Hampshire Medical Laboratories Retirement Income Plan	
	2019	2018	2019	2018	2019	2018
Changes in benefit obligations:						
Projected benefit obligations at beginning of year	$ (270,114,507)	$(284,200,778)	$ (4,140,755)	$ (4,567,286)	$ (2,829,963)	$ (3,062,398)
Service cost	(1,500,000)	(1,500,000)	–	–	(25,000)	(25,000)
Interest cost	(11,301,910)	(10,628,197)	(154,744)	(140,414)	(114,026)	(104,714)
Benefits paid	7,935,050	7,117,759	408,853	411,692	173,921	171,828
Actuarial (loss) gain	(48,841,695)	17,666,264	(174,264)	155,253	(372,806)	173,565
Expenses paid	1,468,125	1,430,445	–	–	16,623	16,756
Projected benefit obligations at end of year	(322,354,937)	(270,114,507)	(4,060,910)	(4,140,755)	(3,151,251)	(2,829,963)
Changes in plan assets:						
Fair value of plan assets at beginning of year	185,414,590	181,485,201	–	–	2,140,827	2,144,861
Actual return on plan assets	5,194,931	12,074,468	–	–	56,327	141,614
Employer contributions	8,141,191	403,125	408,853	411,692	120,167	42,936
Benefits paid	(7,935,050)	(7,117,759)	(408,853)	(411,692)	(173,921)	(171,828)
Expenses paid	(1,468,125)	(1,430,445)	–	–	(16,623)	(16,756)
Fair value of plan assets at end of year	189,347,537	185,414,590	–	–	2,126,777	2,140,827
Funded status of plan at September 30	$ (133,007,400)	$ (84,699,917)	$ (4,060,910)	$ (4,140,755)	$ (1,024,474)	$ (689,136)
Amounts recognized in the balance sheets consist of:						
Current liability	$ –	$ –	$ (391,100)	$ (398,750)	$ –	$ –
Noncurrent liability	(133,007,400)	(84,699,917)	(3,669,810)	(3,742,005)	(1,024,474)	(689,136)
	$ (133,007,400)	$ (84,699,917)	$ (4,060,910)	$ (4,140,755)	$ (1,024,474)	$ (689,136)

The net loss for the defined benefit pension plans that will be amortized from net assets without donor restrictions into net periodic benefit cost over the next fiscal year is $4,686,885.

The current portion of accrued pension costs included in the above amounts for the System amounted to $391,100 and $398,750 at September 30, 2019 and 2018, respectively, and has been included in accounts payable and accrued expenses in the accompanying balance sheets.

The amounts recognized in net assets without donor restrictions for the years ended September 30 consist of:

	Catholic Medical Center Pension Plan		Pre-1987 Supplemental Executive Retirement Plan		New Hampshire Medical Laboratories Retirement Income Plan	
	2019	2018	2019	2018	2019	2018
Amounts recognized in the balance sheets – total plan:						
Net assets without donor restrictions:						
Net loss	$ (160,478,700)	$(105,860,712)	$ (2,141,585)	$ (2,102,034)	$ (1,902,167)	$ (1,492,143)
Net amount recognized	$ (160,478,700)	$(105,860,712)	$ (2,141,585)	$ (2,102,034)	$ (1,902,167)	$ (1,492,143)

9. Retirement Benefits (Continued)

Net periodic pension cost includes the following components for the years ended September 30:

	Catholic Medical Center Pension Plan		Pre-1987 Supplemental Executive Retirement Plan		New Hampshire Medical Laboratories Retirement Income Plan	
	2019	2018	2019	2018	2019	2018
Service cost	$ 1,500,000	$ 1,500,000	$ –	$ –	$ 25,000	$ 25,000
Interest cost	11,301,910	10,628,197	154,744	140,414	114,026	104,714
Expected return on plan assets	(13,738,629)	(13,110,637)	–	–	(155,594)	(153,960)
Amortization of actuarial loss	2,767,405	3,275,000	134,713	147,466	62,049	67,898
Net periodic pension cost	$ 1,830,686	$ 2,292,560	$ 289,457	$ 287,880	$ 45,481	$ 43,652

Other changes in plan assets and benefit obligations recognized in net assets without donor restrictions for the years ended September 30, 2019 and 2018 consist of:

	Catholic Medical Center Pension Plan		Pre-1987 Supplemental Executive Retirement Plan		New Hampshire Medical Laboratories Retirement Income Plan	
	2019	2018	2019	2018	2019	2018
Net loss (gain)	$ 57,388,232	$ (16,630,095)	$ 174,264	$ (155,253)	$ 472,073	$ (161,219)
Amortization of actuarial loss	(2,767,405)	(3,275,000)	(134,713)	(147,466)	(62,049)	(67,898)
Net amount recognized	$ 54,620,827	$ (19,905,095)	$ 39,551	$ (302,719)	$ 410,024	$ (229,117)

The investments of the plans are comprised of the following at September 30:

	Target Allocation		Catholic Medical Center Pension Plan		Pre-1987 Supplemental Executive Retirement Plan		New Hampshire Medical Laboratories Retirement Income Plan	
	2019	2018	2019	2018	2019	2018	2019	2018
Cash and cash equivalents	5.0%	0.0%	3.5%	1.1%	0.0%	0.0%	3.5%	1.1%
Equity securities	65.0	70.0	68.5	66.2	0.0	0.0	68.5	66.2
Fixed income securities	20.0	20.0	24.6	23.7	0.0	0.0	24.6	23.7
Other	10.0	10.0	3.4	9.0	0.0	0.0	3.4	9.0
	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	100.0%	100.0%

The assumption for the long-term rate of return on plan assets has been determined by reflecting expectations regarding future rates of return for the investment portfolio, with consideration given to the distribution of investments by asset class and historical rates of return for each individual asset class.

The weighted-average assumptions used to determine the defined benefit pension plan obligations at September 30 are as follows:

	Catholic Medical Center Pension Plan		Pre-1987 Supplemental Executive Retirement Plan		New Hampshire Medical Laboratories Retirement Income Plan	
	2019	2018	2019	2018	2019	2018
Discount rate	3.12%	4.23%	2.70%	3.93%	2.93%	4.10%
Rate of compensation increase	N/A	N/A	N/A	N/A	N/A	N/A

9. Retirement Benefits (Continued)

The weighted-average assumptions used to determine the defined benefit pension plan net periodic benefit costs for the years ended September 30 are as follows:

	Catholic Medical Center Pension Plan		Pre-1987 Supplemental Executive Retirement Plan		New Hampshire Medical Laboratories Retirement Income Plan	
	2019	2018	2019	2018	2019	2018
Discount rate	4.23%	3.79%	3.93%	3.22%	4.10%	3.52%
Rate of compensation increase	N/A	N/A	N/A	N/A	N/A	N/A
Expected long-term return on plan assets	7.30 %	7.30%	N/A	N/A	7.30%	7.30%

The System expects to make employer contributions totaling $6,500,000 to the Catholic Medical Center Pension Plan for the fiscal year ending September 30, 2020. Expected employer contributions to the Pre-1987 Supplemental Executive Retirement Plan and New Hampshire Medical Laboratories Retirement Income Plan for the fiscal year ending September 30, 2020 are not expected to be significant.

The benefits, which reflect expected future service, as appropriate, expected to be paid for the years ending September 30 are as follows:

	Catholic Medical Center Pension Plan	Pre-1987 Supplemental Executive Retirement Plan	New Hampshire Medical Laboratories Retirement Income Plan
2020	$ 9,243,136	$ 396,345	$194,433
2021	9,993,328	381,634	200,720
2022	10,827,746	366,382	200,423
2023	11,705,953	350,590	200,594
2024	12,473,696	334,272	197,969
2025 - 2029	72,831,683	1,409,626	947,912

The System contributed $8,141,191, $408,853 and $120,167 to the Catholic Medical Center Pension Plan, the Pre-1987 Supplemental Executive Retirement Plan and New Hampshire Medical Laboratories Retirement Income Plan, respectively, for the year ended September 30, 2019. The System contributed $403,125, $411,692 and $42,936 to the Catholic Medical Center Pension Plan, Pre-1987 Supplemental Executive Retirement Plan and the New Hampshire Medical Laboratories Retirement Income Plan, respectively, for the year ended September 30, 2018. The System plans to make any necessary contributions during the upcoming fiscal 2020 year to ensure the plans continue to be adequately funded given the current market conditions.

9. Retirement Benefits (Continued)

The following fair value hierarchy table presents information about the financial assets of the above plans measured at fair value on a recurring basis based upon the lowest level of significant input valuation as of September 30:

	Level 1	Level 2	Level 3	Total
2019				
Cash and cash equivalents	$ 6,607,245	$ –	$ –	$ 6,607,245
Marketable equity securities	48,731,127	–	–	48,731,127
Fixed income securities	47,028,757	–	–	47,028,757
	$102,367,129	$ –	$ –	102,367,129
Investments measured at net asset value:				
Private investment funds				89,107,185
Total assets at fair value				$191,474,314
2018				
Cash and cash equivalents	$ 2,160,634	$ –	$ –	$ 2,160,634
Marketable equity securities	39,221,636	–	–	39,221,636
Fixed income securities	44,497,162	–	–	44,497,162
	$ 85,879,432	$ –	$ –	85,879,432
Investments measured at net asset value:				
Private investment funds				101,675,985
Total assets at fair value				$187,555,417

10. Community Benefits

The System rendered charity care in accordance with its formal charity care policy, which, at established charges, amounted to $22,670,908 and $21,671,846 for the years ended September 30, 2019 and 2018, respectively. Also, the System provides community service programs, without charge, such as the Medication Assistance Program, Community Education and Wellness, Patient Transport, and the Parish Nurse Program. The costs of providing these programs amounted to $977,697 and $983,861 for the years ended September 30, 2019 and 2018, respectively.

11. Functional Expenses

The System provides general health care services to residents within its geographic location including inpatient, outpatient and emergency care. Expenses related to providing these services are as follows at September 30, 2019:

	Healthcare Services	General and Administrative	Total
Salaries, wages and fringe benefits	$241,819,757	$42,827,203	$284,646,960
Supplies and other	132,091,040	37,028,017	169,119,057
New Hampshire Medicaid enhancement tax	21,382,132	–	21,382,132
Depreciation and amortization	10,590,235	6,312,202	16,902,437
Interest	3,178,047	1,045,999	4,224,046
	$409,061,211	$87,213,421	$496,274,632

For the year ended September 30, 2018, the System provided $367,226,914 in health services expenses and $100,350,824 in general and administrative expenses.

The consolidated financial statements report certain expense categories that are attributable to more than one healthcare service or support function. Therefore, these expenses require an allocation on a reasonable basis that is consistently applied. Costs not directly attributable to a function, such as depreciation and interest, are allocated to a function based on square footage. Supporting activities that are not directly identifiable with one or more healthcare programs are classified as general and administrative. If it is impossible or impractical to make a direct identification, allocation of the expenses were made according to management's estimates. Employee benefits are allocated in accordance with the ratio of salaries and wages of the functional classes. Specifically identifiable costs are assigned to the function which they are identified to.

12. Concentration of Credit Risk

The System grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors is as follows at September 30:

	2019	2018
Medicare	45%	44%
Medicaid	12	12
Commercial insurance and other	24	23
Patients (self pay)	5	8
Anthem Blue Cross	14	13
	100%	100%

13. Endowments and Net Assets With Donor Restrictions

Endowments

In July 2008, the State of New Hampshire enacted a version of UPMIFA (the Act). The new law, which had an effective date of July 1, 2008, eliminates the historical dollar threshold and establishes prudent spending guidelines that consider both the duration and preservation of the fund. As a result of this enactment, subject to the donor's intent as expressed in a gift agreement or similar document, a New Hampshire charitable organization may now spend the principal and income of an endowment fund, even from an underwater fund, after considering the factors listed in the Act.

Endowment net assets consist of the following at September 30:

	Without Donor Restrictions	With Donor Restrictions	Total
2019			
Board-designated endowment funds	$110,175,169	$ –	$110,175,169
Donor-restricted endowment funds:			
Original donor-restricted gift amount and amounts required to be maintained in perpetuity by donor	–	7,342,731	7,342,731
Accumulated investment gains	–	2,902,160	2,902,160
Total endowment net assets	$110,175,169	$10,244,891	$120,420,060
2018			
Board-designated endowment funds	$107,832,023	$ –	$107,832,023
Donor-restricted endowment funds:			
Original donor-restricted gift amount and amounts required to be maintained in perpetuity by donor	–	7,342,731	7,342,731
Accumulated investment gains	–	3,084,087	3,084,087
Total endowment net assets	$107,832,023	$10,426,818	$118,258,841

13. Endowments and Net Assets With Donor Restrictions (Continued)

Changes in endowment net assets consisted of the following for the years ended September 30:

	Without Donor Restrictions	With Donor Restrictions	Total
Balance at September 30, 2017	$102,045,292	$ 9,726,007	$111,771,299
Investment return, net	5,658,131	430,243	6,088,374
Contributions	–	646,924	646,924
Appropriation for operations	–	(247,756)	(247,756)
Appropriation for capital	128,600	(128,600)	–
Balance at September 30, 2018	107,832,023	10,426,818	118,258,841
Investment return (loss), net	1,909,136	(63,353)	1,845,783
Contributions	–	536,316	536,316
Appropriation for operations	–	(220,880)	(220,880)
Appropriation for capital	434,010	(434,010)	–
Balance at September 30, 2019	$110,175,169	$10,244,891	$120,420,060

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor requires the Medical Center to retain as a fund of perpetual duration. There were no such deficiencies as of September 30, 2019 or 2018.

Net Assets With Donor Restrictions

Net assets with donor restrictions are available for the following purposes at September 30:

	2019	2018
Funds subject to use or time restrictions:		
Capital acquisitions	$ 258,494	$ 37,941
Health education	909,765	899,288
Indigent care	168,437	253,492
Pledges receivable	758,184	–
	2,094,880	1,190,721
Funds of perpetual duration	9,150,011	9,236,097
	$11,244,891	$10,426,818

14. Investments in Joint Ventures

AAS has a 44% ownership interest in the Bedford Ambulatory Surgical Center. AAS accounts for its investment in this joint venture under the equity method.

AAS has a 50% ownership interest in the Alliance Urgent Care Services, LLC. AAS accounts for its investment in this joint venture under the equity method.

The Medical Center, along with four other participating hospitals and Tufts Health Plan, formed Tufts Health Freedom Plan (THFP), a joint venture. THFP is a health insurance company which began operations as of January 1, 2016. The Medical Center has an approximate 12% ownership interest in this joint venture. Selected financial information relating to the above entities for the years ended September 30, 2019 and 2018 is not shown as such amounts are not significant to the consolidated financial statements.

15. Commitments and Contingencies

Litigation

Various legal claims, generally incidental to the conduct of normal business, are pending or have been threatened against the System. The System intends to defend vigorously against these claims. While ultimate liability, if any, arising from any such claim is presently indeterminable, it is management's opinion that the ultimate resolution of these claims will not have a material adverse effect on the financial condition of the System.

Regulatory

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. Government activity continues with respect to investigations and allegations concerning possible violations by health care providers of fraud and abuse statutes and regulations, which could result in the imposition of significant fines and penalties as well as significant repayments for patient services previously billed. Compliance with such laws and regulations are subject to government review and interpretations as well as regulatory actions unknown or unasserted at this time.

Development Agreement

During fiscal year 2019, the Medical Center entered into a development agreement with PJC Manchester Realty, LLC ("Rite Aid") in regards to the Medical Center's acquisition of certain property owned by Rite Aid. Under the development agreement, the Medical Center acquired the property from Rite Aid for approximately $6.9 million, inclusive of certain costs expected to be incurred to construct a new building that Rite Aid will own and occupy at a separate location. The purchase of the property from Rite Aid allows the Medical Center to expand its campus. As the Medical Center retains title to the project until such time of the second closing, as defined within the development agreement, amounts paid under the development agreement are recorded by the Medical Center as land acquisition costs, and totaled approximately $4.6 million as of September 30, 2019.

The Medical Center has outstanding construction commitments related to this project totaling approximately $8.1 million at September 30, 2019.

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INDEPENDENT AUDITORS' REPORT ON OTHER FINANCIAL INFORMATION

Board of Trustees
CMC Healthcare System, Inc.

We have audited the consolidated financial statements of CMC Healthcare System, Inc. (the System) as of and for the years ended September 30, 2019 and 2018, and have issued our report thereon, which contains an unmodified opinion on those consolidated financial statements. See page 1. Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating information is presented for purposes of additional analysis rather than to present the financial position, results of operations and cash flows of the individual entities and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The consolidating information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Baker Newman & Noyes LLC

Manchester, New Hampshire
February 4, 2020

CMC HEALTHCARE SYSTEM, INC.

CONSOLIDATING BALANCE SHEET

September 30, 2019

ASSETS

	Catholic Medical Center	Physician Practice Associates	Alliance Enterprises	Alliance Resources	Alliance Ambu-latory Services	Alliance Health Services	Doctors Medical Association	Saint Peter's Home	Elimi-nations	Consolidated
Current assets:										
Cash and cash equivalents	$ 47,897,010	$ 2,391,045	$ 3,445,644	$ 705,932	$ 603,153	$ 222,020	$ 75,443	$ 909,243	$ –	$ 56,249,490
Short-term investments	4,021,270	–	–	–	–	–	–	–	–	4,021,270
Accounts receivable, net	78,067,491	–	(3,076)	–	–	1,258,227	–	–	–	79,322,642
Inventories	4,600,802	–	–	–	–	–	–	–	–	4,600,802
Other current assets	12,780,425	(22,443)	14,433	65,943	–	1,335,176	–	24,689	–	14,198,223
Total current assets	147,366,998	2,368,602	3,457,001	771,875	603,153	2,815,423	75,443	933,932	–	158,392,427
Property, plant and equipment, net	118,690,076	–	8,550,580	14,715,075	–	76,528	–	1,079,104	–	143,111,363
Other assets:										
Intangible assets and other	11,869,524	–	–	–	6,731,090	–	–	–	–	18,600,614
Assets whose use is limited:										
Pension and insurance obligations	18,832,810	–	–	–	–	–	–	–	–	18,832,810
Board designated and donor restricted investments and restricted grants	122,116,666	–	–	–	–	–	–	7,225,204	–	129,341,870
Held by trustee under revenue bond agreements	18,845,355	–	–	–	–	–	–	–	–	18,845,355
	159,794,831	–	–	–	–	–	–	7,225,204	–	167,020,035
Total assets	$437,721,429	$ 2,368,602	$12,007,581	$15,486,950	$7,334,243	$2,891,951	$ 75,443	$9,238,240	$ –	$487,124,439

LIABILITIES AND NET ASSETS

	Catholic Medical Center	Physician Practice Associates	Alliance Enterprises	Alliance Resources	Alliance Ambu-latory Services	Alliance Health Services	Doctors Medical Association	Saint Peter's Home	Elimi-nations	Consolidated
Current liabilities:										
Accounts payable and accrued expenses	$ 36,870,043	$ 101,896	$ 116,826	$ 14,945	$ –	$1,557,916	$ 9,312	$ 314,964	$ –	$ 38,985,902
Accrued salaries, wages and related accounts	18,604,407	4,256,637	–	–	–	–	–	112,434	–	22,973,478
Amounts payable to third-party payors	11,456,467	–	–	–	–	–	–	–	–	11,456,467
Due to (from) affiliates	991,062	(876,484)	33,830	(112,489)	–	(17,750)	(16,141)	(2,028)	–	–
Current portion of long-term debt	3,924,079	–	234,000	–	–	–	–	–	–	4,158,079
Total current liabilities	71,846,058	3,482,049	384,656	(97,544)	–	1,540,166	(6,829)	425,370	–	77,573,926
Accrued pension and other liabilities, less current portion	160,696,816	9,869,149	1,041,879	69,526	–	372,466	–	–	–	172,049,836
Long-term debt, less current portion	114,421,351	–	7,462,400	–	–	–	–	–	–	121,883,751
Total liabilities	346,964,225	13,351,198	8,888,935	(28,018)	–	1,912,632	(6,829)	425,370	–	371,507,513
Net assets (deficit):										
Without donor restrictions	79,512,313	(10,982,596)	3,118,646	15,514,968	7,334,243	979,319	82,272	8,812,870	–	104,372,035
With donor restrictions	11,244,891	–	–	–	–	–	–	–	–	11,244,891
Total net assets (deficit)	90,757,204	(10,982,596)	3,118,646	15,514,968	7,334,243	979,319	82,272	8,812,870	–	115,616,926
Total liabilities and net assets	$437,721,429	$ 2,368,602	$12,007,581	$15,486,950	$7,334,243	$2,891,951	$ 75,443	$9,238,240	$ –	$487,124,439

CMC HEALTHCARE SYSTEM, INC.

CONSOLIDATING STATEMENT OF OPERATIONS

Year Ended September 30, 2019

	Catholic Medical Center	Physician Practice Associates	Alliance Enterprises	Alliance Resources	Alliance Ambu-latory Services	Alliance Health Services	Doctors Medical Association	Saint Peter's Home	Eliminations	Consolidated
Net patient service revenues, net of contractual allowances and discounts	$449,484,087	$ –	$ –	$ –	$ –	$16,273,475	$ –	$ –	$ –	$465,757,562
Provision for doubtful accounts	(20,972,163)	–	–	–	–	(672,481)	–	–	–	(21,644,644)
Net patient service revenues less provision for doubtful accounts	428,511,924	–	–	–	–	15,600,994	–	–	–	444,112,918
Other revenue	14,687,063	21,730,371	2,029,569	1,348,691	2,450,518	589,283	114,787	3,296,789	(24,636,486)	21,610,585
Disproportionate share funding	22,566,094	–	–	–	–	–	–	–	–	22,566,094
Total revenues	465,765,081	21,730,371	2,029,569	1,348,691	2,450,518	16,190,277	114,787	3,296,789	(24,636,486)	488,289,597
Expenses:										
Salaries, wages and fringe benefits	227,559,475	59,819,529	25,000	–	–	15,345,730	–	3,293,166	(21,395,940)	284,646,960
Supplies and other	161,282,151	2,859,148	829,215	886,058	–	6,095,729	129,091	278,211	(3,240,546)	169,119,057
New Hampshire Medicaid enhancement tax	21,382,132	–	–	–	–	–	–	–	–	21,382,132
Depreciation and amortization	15,741,819	–	310,579	613,839	–	34,602	–	201,598	–	16,902,437
Interest	3,913,935	–	310,111	–	–	–	–	–	–	4,224,046
Total expenses	429,879,512	62,678,677	1,474,905	1,499,897	–	21,476,061	129,091	3,772,975	(24,636,486)	496,274,632
Income (loss) from operations	35,885,569	(40,948,306)	554,664	(151,206)	2,450,518	(5,285,784)	(14,304)	(476,186)	–	(7,985,035)
Nonoperating gains (losses):										
Investment income	3,875,387	–	–	–	14,106	–	–	231,369	–	4,120,862
Net periodic pension cost, other than service cost	(595,606)	(24,537)	(20,481)	–	–	–	–	–	–	(640,624)
Contributions without donor restrictions	834,004	–	–	–	–	–	–	–	–	834,004
Development costs	(739,596)	–	–	–	–	–	–	–	–	(739,596)
Other nonoperating (loss) gain	(3,153,699)	–	–	–	–	–	–	18,000	–	(3,135,699)
Total nonoperating gains, net	220,490	(24,537)	(20,481)	–	14,106	–	–	249,369	–	438,947
Excess (deficiency) of revenues over expenses	36,106,059	(40,972,843)	534,183	(151,206)	2,464,624	(5,285,784)	(14,304)	(226,817)	–	(7,546,088)
Unrealized appreciation (depreciation) on investments	1,026,222	–	–	–	–	–	–	(114,052)	–	912,170
Change in fair value of interest rate swap agreement	(482,735)	–	–	–	–	–	–	–	–	(482,735)
Assets released from restriction used for capital	434,010	–	–	–	–	–	–	–	–	434,010
Pension-related changes other than net periodic pension cost	(51,110,160)	(3,550,218)	(410,024)	–	–	–	–	–	–	(55,070,402)
Net transfers (to) from affiliates	(46,133,644)	42,163,000	120,167	700,000	(2,500,000)	5,650,000	–	477	–	–
Change in net assets without donor restrictions	$(60,160,248)	$ (2,360,061)	$ 244,326	$ 548,794	$ (35,376)	$ 364,216	$ (14,304)	$ (340,392)	$ –	$(61,753,045)

CMC HEALTHCARE SYSTEM, INC.

CONSOLIDATING BALANCE SHEET

September 30, 2018

ASSETS

	Catholic Medical Center	Physician Practice Associates	Alliance Enterprises	Alliance Resources	Alliance Ambu-latory Services	Alliance Health Services	Doctors Medical Association	Saint Peter's Home	Elimi-nations	Consolidated
Current assets:										
Cash and cash equivalents	$ 57,668,500	$ 22,273	$ 2,745,448	$ 332,128	$ 376,706	$ 166,645	$ 76,949	$ 460,671	$ –	$ 61,849,320
Short-term investments	29,009,260	–	–	–	–	–	–	–	–	29,009,260
Accounts receivable, net	54,074,988	–	–	–	–	1,251,998	–	–	–	55,326,986
Inventories	3,583,228	–	–	–	–	–	–	–	–	3,583,228
Other current assets	9,150,610	3,750	2,537	57,365	286,666	1,139,687	1,608	22,734	–	10,664,957
Total current assets	153,486,586	26,023	2,747,985	389,493	663,372	2,558,330	78,557	483,405	–	160,433,751
Property, plant and equipment, net	109,898,233	–	8,858,160	14,585,192	–	111,130	–	1,145,179	–	134,597,894
Other assets:										
Intangible assets and other	10,875,302	–	–	–	6,706,247	–	–	–	–	17,581,549
Assets whose use is limited:										
Pension and insurance obligations	17,859,458	–	–	–	–	–	–	–	–	17,859,458
Board designated and donor restricted investments and restricted grants	119,411,378	1,488	–	–	–	–	–	7,854,219	–	127,267,085
Held by trustee under revenue bond agreements	36,660,053	–	–	–	–	–	–	–	–	36,660,053
	173,930,889	1,488	–	–	–	–	–	7,854,219	–	181,786,596
Total assets	$448,191,010	$ 27,511	$11,606,145	$14,974,685	$7,369,619	$2,669,460	$ 78,557	$9,482,803	$ –	$494,399,790

LIABILITIES AND NET ASSETS

	Catholic Medical Center	Physician Practice Associates	Alliance Enterprises	Alliance Resources	Alliance Ambu-latory Services	Alliance Health Services	Doctors Medical Association	Saint Peter's Home	Elimi-nations	Consolidated
Current liabilities:										
Accounts payable and accrued expenses	$ 28,743,870	$ 68,143	$ 90,029	$ 17,169	$ –	$1,660,520	$ 5,590	$ 203,832	$ –	$ 30,789,153
Accrued salaries, wages and related accounts	18,755,583	3,791,797	–	–	–	–	–	126,109	–	22,673,489
Amounts payable to third-party payors	14,643,104	–	–	–	–	–	–	–	–	14,643,104
Due to (from) affiliates	1,477,267	(1,392,988)	16,867	(80,123)	–	2,986	(23,609)	(400)	–	–
Current portion of long-term debt	4,131,199	–	234,000	–	–	–	–	–	–	4,365,199
Total current liabilities	67,751,023	2,466,952	340,896	(62,954)	–	1,663,506	(18,019)	329,541	–	72,470,945
Accrued pension and other liabilities, less current portion	115,111,279	6,183,094	706,541	71,465	–	390,851	–	–	–	122,463,230
Long-term debt, less current portion	115,229,329	–	7,684,388	–	–	–	–	–	–	122,913,717
Total liabilities	298,091,631	8,650,046	8,731,825	8,511	–	2,054,357	(18,019)	329,541	–	317,847,892
Net assets (deficit):										
Without donor restrictions	139,672,561	(8,622,535)	2,874,320	14,966,174	7,369,619	615,103	96,576	9,153,262	–	166,125,080
With donor restrictions	10,426,818	–	–	–	–	–	–	–	–	10,426,818
Total net assets (deficit)	150,099,379	(8,622,535)	2,874,320	14,966,174	7,369,619	615,103	96,576	9,153,262	–	176,551,898
Total liabilities and net assets	$448,191,010	$ 27,511	$11,606,145	$14,974,685	$7,369,619	$2,669,460	$ 78,557	$9,482,803	$ –	$494,399,790

CMC HEALTHCARE SYSTEM, INC.

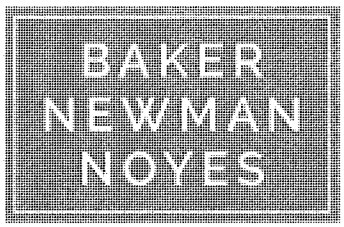
CONSOLIDATING STATEMENT OF OPERATIONS

Year Ended September 30, 2018

	Catholic Medical Center	Physician Practice Associates	Alliance Enterprises	Alliance Resources	Alliance Ambu-latory Services	Alliance Health Services	Doctors Medical Association	Saint Peter's Home	Eliminations	Consolidated
Net patient service revenues, net of contractual allowances and discounts	$436,357,697	$ –	$ –	$ –	$ –	$16,152,678	$ –	$ –	$ –	$452,510,375
Provision for doubtful accounts	(19,593,714)	–	–	–	–	(740,535)	–	–	–	(20,334,249)
Net patient service revenues less provision for doubtful accounts	416,763,983	–	–	–	–	15,412,143	–	–	–	432,176,126
Other revenue	12,515,169	24,664,782	2,026,051	1,306,175	2,685,142	572,119	131,102	3,090,287	(27,536,141)	19,454,686
Disproportionate share funding	17,993,289	–	–	–	–	–	–	–	–	17,993,289
Total revenues	447,272,441	24,664,782	2,026,051	1,306,175	2,685,142	15,984,262	131,102	3,090,287	(27,536,141)	469,624,101
Expenses:										
Salaries, wages and fringe benefits	217,868,046	55,518,048	25,000	–	–	14,377,316	–	3,020,016	(23,995,148)	266,813,278
Supplies and other	153,527,155	2,191,509	752,790	1,016,430	–	5,867,844	142,023	333,456	(3,540,993)	160,290,214
New Hampshire Medicaid enhancement tax	19,968,497	–	–	–	–	–	–	–	–	19,968,497
Depreciation and amortization	14,972,724	–	333,910	594,149	–	41,518	–	194,683	–	16,136,984
Interest	3,933,617	–	435,148	–	–	–	–	–	–	4,368,765
Total expenses	410,270,039	57,709,557	1,546,848	1,610,579	–	20,286,678	142,023	3,548,155	(27,536,141)	467,577,738
Income (loss) from operations	37,002,402	(33,044,775)	479,203	(304,404)	2,685,142	(4,302,416)	(10,921)	(457,868)	–	2,046,363
Nonoperating gains (losses):										
Investment income	5,699,700	–	158,797	6	3,429	–	–	224,862	–	6,086,794
Net periodic pension cost, other than service cost	(1,023,371)	(57,068)	(18,653)	–	–	–	–	–	–	(1,099,092)
Contributions without donor restrictions	629,198	–	–	–	–	–	–	–	–	629,198
Development costs	(635,408)	–	–	–	–	–	–	–	–	(635,408)
Other nonoperating (loss) gain	(511,679)	–	8,285	–	–	–	–	14,100	–	(489,294)
Total nonoperating gains (losses), net	4,158,440	(57,068)	148,429	6	3,429	–	–	238,962	–	4,492,198
Excess (deficiency) of revenues over expenses	41,160,842	(33,101,843)	627,632	(304,398)	2,688,571	(4,302,416)	(10,921)	(218,906)	–	6,538,561
Unrealized appreciation on investments	2,184,604	–	–	–	–	–	–	140,547	–	2,325,151
Change in fair value of interest rate swap agreement	302,826	–	–	–	–	–	–	–	–	302,826
Assets released from restriction used for capital	128,600	–	–	–	–	–	–	–	–	128,600
Pension-related changes other than net periodic pension cost	18,843,760	1,364,053	229,118	–	–	–	–	–	–	20,436,931
Net transfers (to) from affiliates	(35,782,824)	31,967,000	223,054	1,112,760	(1,650,000)	4,130,000	–	10	–	–
Change in net assets without donor restrictions	$ 26,837,808	$ 229,210	$1,079,804	$ 808,362	$ 1,038,571	$ (172,416)	$(10,921)	$ (78,349)	$ –	$ 29,732,069

Attachment 6

CMC Audited Financial Statements FY 2019



Catholic Medical Center

Audited Financial Statements

Years Ended September 30, 2019 and 2018
With Independent Auditors' Report

Baker Newman & Noyes LLC
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CATHOLIC MEDICAL CENTER

AUDITED FINANCIAL STATEMENTS

Years Ended September 30, 2019 and 2018

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INDEPENDENT AUDITORS' REPORT

Board of Trustees
Catholic Medical Center

We have audited the accompanying financial statements of Catholic Medical Center, which comprise the balance sheets as of September 30, 2019 and 2018, and the related statements of operations, changes in net assets and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

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

Board of Trustees
Catholic Medical Center

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Catholic Medical Center as of September 30, 2019 and 2018, and the results of its operations, changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter

As discussed in Note 2 to the financial statements, in 2019, Catholic Medical Center adopted the provisions of Financial Accounting Standards Board Accounting Standards Update No. 2016-14, *Not-for-Profit Entities (Topic 958) - Presentation of Financial Statements of Not-for-Profit Entities* and applied the guidance retrospectively for all periods presented. Our opinion is not modified with respect to this matter.

Baker Newman & Noyes LLC

Manchester, New Hampshire
February 4, 2020

CATHOLIC MEDICAL CENTER

BALANCE SHEETS

September 30, 2019 and 2018

ASSETS

	2019	2018
Current assets:		
Cash and cash equivalents	$ 47,897,010	$ 57,668,500
Short-term investments	4,021,270	29,009,260
Accounts receivable, less allowance for doubtful accounts of $19,786,141 in 2019 and $19,525,261 in 2018	78,067,491	54,074,988
Inventories	4,600,802	3,583,228
Other current assets	12,780,425	9,150,610
Total current assets	147,366,998	153,486,586
Property, plant and equipment, net	118,690,076	109,898,233
Other assets:		
Intangible assets and other	11,869,524	10,875,302
Assets whose use is limited:		
Pension and insurance obligations	18,832,810	17,859,458
Board designated and donor restricted investments and restricted grants	122,116,666	119,411,378
Held by trustee under revenue bond agreements	18,845,355	36,660,053
	159,794,831	173,930,889
Total assets	$437,721,429	$448,191,010

LIABILITIES AND NET ASSETS

	2019	2018
Current liabilities:		
Accounts payable and accrued expenses	$ 36,870,043	$ 28,743,870
Accrued salaries, wages and related accounts	18,604,407	18,755,583
Amounts payable to third-party payors	11,456,467	14,643,104
Amounts due to affiliates	991,062	1,477,267
Current portion of long-term debt	3,924,079	4,131,199
Total current liabilities	71,846,058	67,751,023
Accrued pension and other liabilities, less current portion	160,696,816	115,111,279
Long-term debt, less current portion	114,421,351	115,229,329
Total liabilities	346,964,225	298,091,631
Net assets:		
Without donor restrictions	79,512,313	139,672,561
With donor restrictions	11,244,891	10,426,818
Total net assets	90,757,204	150,099,379
Total liabilities and net assets	$437,721,429	$448,191,010

See accompanying notes.

CATHOLIC MEDICAL CENTER

STATEMENTS OF OPERATIONS

Years Ended September 30, 2019 and 2018

	2019	2018
Net patient service revenues, net of contractual allowances and discounts	$449,484,087	$436,357,697
Provision for doubtful accounts	(20,972,163)	(19,593,714)
Net patient service revenues less provision for doubtful accounts	428,511,924	416,763,983
Other revenue	14,687,063	12,515,169
Disproportionate share funding	22,566,094	17,993,289
Total revenues	465,765,081	447,272,441
Expenses:		
Salaries, wages and fringe benefits	227,559,475	217,868,046
Supplies and other	161,282,151	153,527,155
New Hampshire Medicaid enhancement tax	21,382,132	19,968,497
Depreciation and amortization	15,741,819	14,972,724
Interest	3,913,935	3,933,617
Total expenses	429,879,512	410,270,039
Income from operations	35,885,569	37,002,402
Nonoperating gains (losses):		
Investment income, net	3,875,387	5,699,700
Net periodic pension cost, other than service cost	(595,606)	(1,023,371)
Contributions without donor restrictions	834,004	629,198
Development costs	(739,596)	(635,408)
Other nonoperating loss	(3,153,699)	(511,679)
Total nonoperating gains, net	220,490	4,158,440
Excess of revenues and gains over expenses	36,106,059	41,160,842
Unrealized appreciation on investments	1,026,222	2,184,604
Change in fair value of interest rate swap agreement	(482,735)	302,826
Assets released from restriction used for capital	434,010	128,600
Pension-related changes other than net periodic pension cost	(51,110,160)	18,843,760
Net assets transferred to affiliates	(46,133,644)	(35,782,824)
Change in net assets without donor restrictions	(60,160,248)	26,837,808
Net assets without donor restrictions at beginning of year	139,672,561	112,834,753
Net assets without donor restrictions at end of year	$ 79,512,313	$139,672,561

See accompanying notes.

CATHOLIC MEDICAL CENTER

STATEMENTS OF CHANGES IN NET ASSETS

Years Ended September 30, 2019 and 2018

	Net Assets Without Donor Restrictions	Net Assets With Donor Restrictions	Total Net Assets
Balances at September 30, 2017	$ 112,834,753	$ 9,726,007	$122,560,760
Excess of revenues and gains over expenses	41,160,842	–	41,160,842
Restricted investment income	–	27,373	27,373
Changes in interest in perpetual trust	–	341,439	341,439
Donor-restricted contributions	–	646,924	646,924
Unrealized appreciation on investments	2,184,604	61,431	2,246,035
Change in fair value of interest rate swap agreement	302,826	–	302,826
Assets released from restriction used for operations	–	(247,756)	(247,756)
Assets released from restriction used for capital	128,600	(128,600)	–
Pension-related changes other than net periodic pension cost	18,843,760	–	18,843,760
Net assets transferred to affiliates	(35,782,824)	–	(35,782,824)
	26,837,808	700,811	27,538,619
Balances at September 30, 2018	139,672,561	10,426,818	150,099,379
Excess of revenues and gains over expenses	36,106,059	–	36,106,059
Restricted investment income	–	31,596	31,596
Changes in interest in perpetual trust	–	(110,168)	(110,168)
Donor-restricted contributions	–	1,536,316	1,536,316
Unrealized appreciation on investments	1,026,222	15,219	1,041,441
Change in fair value of interest rate swap agreement	(482,735)	–	(482,735)
Assets released from restriction used for operations	–	(220,880)	(220,880)
Assets released from restriction used for capital	434,010	(434,010)	–
Pension-related changes other than net periodic pension cost	(51,110,160)	–	(51,110,160)
Net assets transferred to affiliates	(46,133,644)	–	(46,133,644)
	(60,160,248)	818,073	(59,342,175)
Balances at September 30, 2019	$ 79,512,313	$11,244,891	$ 90,757,204

See accompanying notes.

CATHOLIC MEDICAL CENTER

STATEMENTS OF CASH FLOWS

Years Ended September 30, 2019 and 2018

	2019	2018
Operating activities:		
Change in net assets	$ (59,342,175)	$ 27,538,619
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	15,741,819	14,972,724
Pension-related changes other than net periodic pension cost	51,110,160	(18,843,760)
Net assets transferred to affiliates	46,133,644	35,782,824
Restricted gifts and investment income	(1,567,912)	(674,297)
Net realized and unrealized gains on investments	(969,582)	(5,099,360)
Change in interest in perpetual trust	110,168	(341,439)
Change in fair value of interest rate swap agreement	482,735	(302,826)
Bond discount/premium and issuance cost amortization	(301,980)	(324,032)
Changes in operating assets and liabilities:		
Accounts receivable, net	(23,992,503)	(5,692,536)
Inventories	(1,017,574)	(176,408)
Other current assets	(3,629,815)	1,660,997
Amounts due to affiliates	(486,205)	71,377
Other assets	(1,024,839)	(343,421)
Accounts payable and accrued expenses	6,874,483	(5,518,601)
Accrued salaries, wages and related accounts	(151,176)	1,948,851
Amounts payable to third-party payors	(3,186,637)	291,782
Accrued pension and other liabilities	(6,018,750)	6,250,950
Net cash provided by operating activities	18,763,861	51,201,444
Investing activities:		
Purchases of property, plant and equipment	(23,239,963)	(35,831,031)
Net change in assets held by trustee under revenue bond agreements	17,814,698	14,819,012
Proceeds from sales of investments	52,750,600	23,284,364
Purchases of investments	(29,781,836)	(31,034,584)
Net cash provided (used) by investing activities	17,543,499	(28,762,239)
Financing activities:		
Payments on long-term debt	(3,455,000)	(3,330,000)
Proceeds from long-term debt	3,513,632	–
Payments on capital leases	(676,199)	(707,299)
Bond issuance costs	(95,551)	–
Restricted gifts and investment income	767,912	674,297
Net assets transferred to affiliates	(46,133,644)	(35,782,824)
Net cash used by financing activities	(46,078,850)	(39,145,826)
Decrease in cash and cash equivalents	(9,771,490)	(16,706,621)
Cash and cash equivalents at beginning of year	57,668,500	74,375,121
Cash and cash equivalents at end of year	$ 47,897,010	$ 57,668,500

Supplemental disclosure:
At September 30, 2019, amounts totaling $1,251,690 related to the purchase of property, plant and equipment were included in accounts payable and accrued expenses.

See accompanying notes.

1. Organization

Catholic Medical Center (the Medical Center) is a voluntary not-for-profit acute care hospital based in Manchester, New Hampshire. The Medical Center, which primarily serves residents of New Hampshire and northern Massachusetts, was controlled by CMC Healthcare System, Inc. (the System), a not-for-profit corporation which functioned as the parent company and sole member of the Medical Center until December 31, 2016, as discussed below.

On December 30, 2016, the System became affiliated with Huggins Hospital (HH), a 25-bed critical access hospital in Wolfeboro, New Hampshire, and Monadnock Community Hospital (MCH), a 25-bed critical access hospital in Peterborough, New Hampshire, through the formation of a common parent, GraniteOne Health (GraniteOne). GraniteOne is a New Hampshire voluntary corporation that is recognized as being a Section 501(c)(3) tax-exempt and "supporting organization" within the meaning of Section 509(a)(3) of the Internal Revenue Code of 1986, as amended (the Code). GraniteOne serves as the sole member of HH and MCH and co-member of the Medical Center, along with the System. GraniteOne is governed by a thirteen member Board of Trustees appointed by each of the respective hospitals within the GraniteOne system. The GraniteOne Board of Trustees governs the GraniteOne system through the existence and execution of reserved powers to approve certain actions by the Boards of Trustees of each of the hospitals. Through GraniteOne, this more integrated healthcare system enhances the affiliated hospitals' ability to coordinate the delivery of patient care, implement best practices, eliminate inefficiencies and collaborate on regional planning. These efforts strengthen the hospitals' ability to meet the healthcare needs of their respective communities and provide for a more seamless patient experience across the continuum of care. The accompanying financial statements for the years ended September 30, 2019 and 2018 do not include the accounts and activity of GraniteOne, HH and MCH.

On September 30, 2019, GraniteOne, the Medical Center, the System, certain subsidiaries of the System, HH and MCH entered into a Combination Agreement (the Agreement) with Dartmouth-Hitchcock Health (D-HH) to combine GraniteOne and D-HH and its members into a more fully integrated healthcare delivery system. Pursuant to the terms of the Agreement, the parties intend to revise D-HH's corporate name to Dartmouth-Hitchcock Health GraniteOne (D-HH GO), which will continue to serve as the sole corporate member of the existing D-HH System Members (Mary Hitchcock Memorial Health and Dartmouth-Hitchcock Clinic, New London Hospital (NLH), Cheshire Medical Center (Cheshire), Mt. Ascutney Hospital and Health Center (MAHHC), Alice Peck Day Memorial Hospital (APD) and Visiting Nurse and Hospice for Vermont and New Hampshire (VNH)), and which will be substituted for GraniteOne as the sole corporate member of HH and MCH and as co-member, of the Medical Center and certain subsidiaries of the System (the Combination). The overarching goal of the Combination is to create a New Hampshire-based, integrated and regionally distributed health care delivery system that better serves its patients and communities. While the System will not be a component of the D-HH GO System, it will continue to serve as the corporate vehicle through which the Bishop of the Diocese of Manchester (the Bishop) ensures the Medical Center's adherence to the Ethical and Religious Directives for Catholic Health Care Services. Neither the System nor the Bishop will have authority over any other D-HH GO System Member, including HH and MCH. Subject to certain rights reserved to the Bishop and the System with respect to the Medical Center and the System's subsidiaries, D-HH GO will reserve to itself certain approval and initiation powers over the governance, financial, programmatic, administrative, and strategic decisions of D-HH GO System Members.

1. Organization (Continued)

On December 30, 2019, GraniteOne, the Medical Center, HH and MCH submitted a Joint Notice of Change of Control to the New Hampshire Attorney General, Director of Charitable Trusts pursuant to New Hampshire RSA 7:19-b beginning the regulatory review and approval process of the Combination. If all necessary approvals are obtained and closing conditions satisfied, D-HH GO will consist of a major academic medical center offering tertiary and quaternary services, an acute care community hospital in an urban setting (the Medical Center), an acute care community hospital in a rural setting (Cheshire), five rural critical access hospitals (NLH, MAHHC, APD, HH and MCH), a post-acute home health and hospice provider (VNH), and nearly 1,800 employed and affiliated primary and specialty care physicians. D-HH GO System Members will combine their resources to offer a broader array of inpatient, outpatient and ambulatory services.

2. Significant Accounting Policies

Basis of Presentation

The accompanying financial statements have been prepared using the accrual basis of accounting.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America (U.S. GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities as of the date of the financial statements. Estimates also affect the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates. The primary estimates relate to collectibility of receivables from patients and third-party payors, amounts payable to third-party payors, accrued compensation and benefits, conditional asset retirement obligations, and self-insurance reserves.

Income Taxes

The Medical Center is a not-for-profit corporation as described in Section 501(c)(3) of the Code and is exempt from federal income taxes on related income pursuant to Section 501(a) of the Code. Management evaluated the Medical Center's tax positions and concluded the Medical Center has maintained its tax-exempt status, does not have any significant unrelated business income and had taken no uncertain tax positions that require adjustment to the financial statements.

Performance Indicator

Excess of revenues and gains over expenses is comprised of operating revenues and expenses and nonoperating gains and losses. For purposes of display, transactions deemed by management to be ongoing, major or central to the provision of health care services are reported as operating revenue and expenses. Peripheral or incidental transactions are reported as nonoperating gains or losses, which include contributions without donor restrictions, development costs, net investment income (including realized gains and losses on sales of investments), net periodic pension costs (other than service cost), other nonoperating losses and contributions to community agencies.

2. Significant Accounting Policies (Continued)

Charity Care and Community Benefits

The Medical Center has a formal charity care policy under which patient care is provided to patients who meet certain criteria without charge or at amounts less than its established rates. The Medical Center does not pursue collection of amounts determined to qualify as charity care; therefore, they are not reported as revenues. The Medical Center rendered charity care in accordance with this policy, which, at established charges, amounted to $22,371,381 and $21,393,063 for the years ended September 30, 2019 and 2018, respectively.

Of the Medical Center's $429,879,512 total expenses reported for the year ended September 30, 2019, an estimated $6,900,000 arose from providing services to charity patients. Of the Medical Center's $410,270,039 total expenses reported for the year ended September 30, 2018, an estimated $6,700,000 arose from providing services to charity patients. The estimated costs of providing charity services are based on a calculation which applies a ratio of costs to charges to the gross uncompensated charges associated with providing care to charity patients. The ratio of cost to charges is calculated based on the Medical Center's total expenses divided by gross patient service revenue.

The Medical Center provides community service programs, without charge, such as the Medication Assistance Program, Community Education and Wellness, Patient Transport, and the Parish Nurse Program. The costs of providing these programs amounted to $977,697 and $983,861 for the years ended September 30, 2019 and 2018, respectively.

Concentration of Credit Risk

Financial instruments which subject the Medical Center to credit risk consist primarily of cash equivalents, accounts receivable and investments. The risk with respect to cash equivalents is minimized by the Medical Center's policy of investing in financial instruments with short-term maturities issued by highly rated financial institutions. The Medical Center's accounts receivable are primarily due from third-party payors and amounts are presented net of expected contractual allowances and uncollectible amounts. The Medical Center's investment portfolio consists of diversified investments, which are subject to market risk. Investments that exceeded 10% of investments include the SSGA S&P 500 Tobacco Free Fund and the Dreyfus Treasury Securities Cash Management Fund as of September 30, 2019 and 2018.

Cash and Cash Equivalents

Cash and cash equivalents include certificates of deposit with maturities of three months or less when purchased and investments in overnight deposits at various banks. Cash and cash equivalents exclude amounts whose use is limited by board designation and amounts held by trustees under revenue bond and other agreements. The Medical Center maintains approximately $44,000,000 and $56,000,000 at September 30, 2019 and 2018, respectively, of its cash and cash equivalent accounts with a single institution. The Medical Center has not experienced any losses associated with deposits at this institution.

2. Significant Accounting Policies (Continued)

Net Patient Service Revenues and Accounts Receivable

The Medical Center has agreements with third-party payors that provide for payments at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, per diem payments and fee schedules. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the year the related services are rendered and adjusted in future years as final settlements are determined. Changes in these estimates are reflected in the financial statements in the year in which they occur.

The Medical Center recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered. For uninsured patients, the Medical Center provides a discount approximately equal to that of its largest private insurance payors.

The provision for doubtful accounts is based upon management's assessment of historical and expected net collections considering historical business and economic conditions, trends in health care coverage, and other collection indicators. The Medical Center records a provision for doubtful accounts in the year services are provided related to self-pay patients, including both uninsured patients and patients with deductible and copayment balances due for which third-party coverage exists for a portion of their balance.

Periodically, management assesses the adequacy of the allowance for doubtful accounts based upon historical write-off experience. The results of this review are then used to make any modifications to the provision for doubtful accounts to establish an appropriate allowance for doubtful accounts. Accounts receivable are written off after collection efforts have been followed in accordance with internal policies.

Inventories

Inventories of supplies are stated at the lower of cost (determined by the first-in, first-out method) or net realizable value.

Property, Plant and Equipment

Property, plant and equipment is stated at cost at time of purchase or fair value at the time of donation, less accumulated depreciation. The Medical Center's policy is to capitalize expenditures for major improvements and charge maintenance and repairs currently for expenditures which do not extend the lives of the related assets. The provisions for depreciation and amortization have been determined using the straight-line method at rates intended to amortize the cost of assets over their estimated useful lives, which range from 2 to 40 years. Assets which have been purchased but not yet placed in service are included in construction in progress and no depreciation expense is recorded.

2. Significant Accounting Policies (Continued)

Conditional Asset Retirement Obligations

The Medical Center recognizes the fair value of a liability for legal obligations associated with asset retirements in the year in which the obligation is incurred, in accordance with the Accounting Standards for *Accounting for Asset Retirement Obligations* (ASC 410-20). When the liability is initially recorded, the cost of the asset retirement obligation is capitalized by increasing the carrying amount of the related long lived asset. The liability is accreted to its present value each year, and the capitalized cost associated with the retirement obligation is depreciated over the useful life of the related asset. Upon settlement of the obligation, any difference between the cost to settle the asset retirement obligation and the liability recorded is recognized as a gain or loss in the statements of operations.

As of September 30, 2019 and 2018, $958,666 and $1,001,165, respectively, of conditional asset retirement obligations are included within accrued pension and other liabilities in the accompanying balance sheets.

Goodwill

The Medical Center reviews its goodwill and other long-lived assets annually to determine whether the carrying amount of such assets is impaired. Upon determination that an impairment has occurred, these assets are reduced to fair value. There were no impairments recorded for the years ended September 30, 2019 or 2018.

Retirement Benefits

The Catholic Medical Center Pension Plan (the Plan) provides retirement benefits for certain employees of the Medical Center and certain employees of an affiliated organization who have attained age twenty-one and work at least 1,000 hours per year. The Plan consists of a benefit accrued to July 1, 1985, plus 2% of plan year earnings (to legislative maximums) per year. The Medical Center's funding policy is to contribute amounts to the Plan sufficient to meet minimum funding requirements set forth in the Employee Retirement Income Security Act of 1974, plus such additional amounts as may be determined to be appropriate from time to time. The Plan is intended to constitute a plan described in Section 414(k) of the Code, under which benefits derived from employer contributions are based on the separate account balances of participants in addition to the defined benefits under the Plan.

Effective January 1, 2008 the Medical Center decided to close participation in the Plan to new participants. As of January 1, 2008, current participants continued to participate in the Plan while new employees receive a higher matching contribution to the tax-sheltered annuity benefit program discussed below.

During 2011, the Board of Trustees voted to freeze the accrual of benefits under the Plan effective December 31, 2011.

The Plan was amended effective as of May 1, 2016 to provide a limited opportunity for certain terminated vested participants to elect an immediate lump sum or annuity distribution option.

2. Significant Accounting Policies (Continued)

The Medical Center also maintains tax-sheltered annuity benefit programs in which it matches one half of employee contributions up to 3% of their annual salary, depending on date of hire, plus an additional 3% - 5% based on tenure. The Medical Center made matching contributions under the program of $6,532,030 and $5,942,550 for the years ended September 30, 2019 and 2018, respectively.

During 2007, the Medical Center created a nonqualified deferred compensation plan covering certain employees under Section 457(b) of the Code. Under the plan, a participant may elect to defer a portion of their compensation to be held until payment in the future to the participant or his or her beneficiary. Consistent with the requirements of the Code, all amounts of deferred compensation, including but not limited to any investments held and all income attributable to such amounts, property, and rights will remain subject to the claims of the Medical Center's creditors, without being restricted to the payment of deferred compensation, until payment is made to the participant or their beneficiary. No contributions were made by the Medical Center for the years ended September 30, 2019 or 2018.

The Medical Center also provides a noncontributory supplemental executive retirement plan covering certain former executives of the Medical Center, as defined. The Medical Center's policy is to accrue costs under this plan using the "Projected Unit Credit Actuarial Cost Method" and to amortize past service costs over a fifteen year period. Benefits under this plan are based on the participant's final average salary, social security benefit, retirement income plan benefit, and total years of service. Certain investments have been designated for payment of benefits under this plan and are included in assets whose use is limited–pension and insurance obligations.

During 2007, the Medical Center created a supplemental executive retirement plan covering certain executives of the Medical Center under Section 457(f) of the Code. The Medical Center recorded compensation expense of $661,215 and $682,820 for the years ended September 30, 2019 and 2018, respectively related to this plan.

Employee Fringe Benefits

The Medical Center has an "earned time" plan. Under this plan, each qualifying employee "earns" hours of paid leave for each pay period worked. These hours of paid leave may be used for vacations, holidays, or illness. Hours earned but not used are vested with the employee and are paid to the employee upon termination. The Medical Center expenses the cost of these benefits as they are earned by the employees.

Debt Issuance Costs/Original Issue Discount or Premium

The debt issuance costs incurred to obtain financing for the Medical Center's construction and renovation programs and refinancing of prior bonds and the original issue discount or premium are amortized to interest expense using the effective interest method over the repayment period of the bonds. The original issue discount or premium and debt issuance costs are presented as a component of long-term debt.

Assets Whose Use is Limited or Restricted

Assets whose use is limited or restricted include assets held by trustees under indenture agreements, pension and insurance obligations, designated assets set aside by the Board of Trustees, over which the Board retains control and may, at its discretion, subsequently use for other purposes, and donor-restricted investments.

2. Significant Accounting Policies (Continued)

Net Assets With Donor Restrictions

Gifts are reported as restricted support if they are received with donor stipulations that limit the use of donated assets. Donated investments, supplies and equipment are reported at fair value at the date of receipt. Unconditional promises to give cash and other assets are reported at fair value at the date of the receipt of the promise. When a donor restriction expires (when a stipulated time restriction ends or purpose restriction is accomplished), net assets with donor restrictions are reclassified as net assets without donor restrictions and reported in the statements of operations as either net assets released from restrictions (for noncapital related items) or as net assets released from restrictions used for capital purchases (capital related items). Some net assets with donor restrictions have been restricted by donors to be maintained by the Medical Center in perpetuity.

Except for contributions related to capital purchases, donor-restricted contributions whose restrictions are met within the same year as received are reported as contributions within net assets without donor restrictions in the accompanying financial statements.

Pledges Receivable

Pledges receivable are recognized as revenue when the unconditional promise to give is made. Pledges expected to be collected within one year are recorded at their net realizable value. Pledges that are expected to be collected in future years are recorded at the present value of estimated future cash flows. The present value of estimated future cash flows is measured utilizing risk-free rates of return adjusted for market and credit risk established at the time a contribution is received.

Investments and Investment Income

Investments are carried at fair value in the accompanying balance sheets. See Note 8 for further discussion regarding fair value measurements. Investment income (including realized gains and losses on investments and interest and dividends) is included in the excess of revenues and gains over expenses unless the income is restricted by donor or law, in which case it is reported as an increase or decrease in net assets with donor restrictions. Realized gains or losses on the sale of investment securities are determined by the specific identification method and are recorded on the settlement date. Unrealized gains and losses on investments are excluded from the excess of revenues and gains over expenses unless the investments are classified as trading securities or losses are considered other-than-temporary.

Derivative Instruments

Derivatives are recognized as either assets or liabilities in the balance sheets at fair value regardless of the purpose or intent for holding the instrument. Changes in the fair value of derivatives are recognized either in the excess of revenues and gains over expenses or net assets, depending on whether the derivative is speculative or being used to hedge changes in fair value or cash flows. See also Note 6.

2. Significant Accounting Policies (Continued)

Beneficial Interest in Perpetual Trust

The Medical Center is the beneficiary of trust funds administered by trustees or other third parties. Trusts wherein the Medical Center has the irrevocable right to receive the income earned on the trust assets in perpetuity are recorded as net assets with donor restrictions at the fair value of the trust at the date of receipt. Income distributions from the trusts are reported as investment income that increase net assets without donor restrictions, unless restricted by the donor. Annual changes in the fair value of the trusts are recorded as increases or decreases to net assets with donor restrictions.

Endowment, Investment and Spending Policies

In accordance with the *Uniform Prudent Management of Institutional Funds Act* (UPMIFA), the Medical Center considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: (a) the duration and preservation of the fund; (b) the purpose of the organization and the donor-restricted endowment fund; (c) general economic conditions; (d) the possible effect of inflation and deflation; (e) the expected total return from income and the appreciation of investments; (f) other resources of the organization; and (g) the investment policies of the organization.

Spending policies may be adopted by the Medical Center, from time to time, to provide a stream of funding for the support of key programs. The spending policies are structured in a manner to ensure that the purchasing power of the assets is maintained while providing the desired level of annual funding to the programs. The Medical Center currently has a policy allowing interest and dividend income earned on investments to be used for operations with the goal of keeping principal, including its appreciation, intact.

The Medical Center's investment policies provide guidance for the prudent and skillful management of invested assets with the objective of preserving capital and maximizing returns. The invested assets include endowment, specific purpose and board designated funds.

Endowment funds are identified as perpetual in nature, intended to provide support for current or future operations and other purposes identified by the donor. These funds are managed with disciplined longer-term investment objectives and strategies designed to accommodate relevant, reasonable, or probable events.

Specific purpose funds are temporary in nature, restricted as to time or purpose as identified by the donor or grantor. These funds have various intermediate/long-term time horizons associated with specific identified spending objectives.

Board designated funds have various intermediate/long-term time horizons associated with specific spending objectives as determined by the Board of Trustees.

Management of these assets is designed to maximize total return while preserving the capital values of the funds, protecting the funds from inflation and providing liquidity as needed. The objective is to provide a real rate of return that meets inflation, plus 4% to 5%, over a long-term time horizon.

The Medical Center targets a diversified asset allocation that places emphasis on achieving its long-term return objectives within prudent risk constraints.

2. Significant Accounting Policies (Continued)

Federal Grant Revenue and Expenditures

Revenues and expenses under federal grant programs are recognized as the related expenditure is incurred.

Malpractice Loss Contingencies

The Medical Center has a claims-made basis policy for its malpractice insurance coverage. A claims-made basis policy provides specific coverage for claims reported during the policy term. The Medical Center has established a reserve to cover professional liability exposure, which may not be covered by insurance. The possibility exists, as a normal risk of doing business, that malpractice claims in excess of insurance coverage may be asserted against the Medical Center. In the event a loss contingency should occur, the Medical Center would give it appropriate recognition in its financial statements in conformity with accounting standards. The Medical Center expects to be able to obtain renewal or other coverage in future years.

In accordance with Accounting Standards Update (ASU) No. 2010-24, "*Health Care Entities*" (Topic 954): *Presentation of Insurance Claims and Related Insurance Recoveries*, at September 30, 2019 and 2018, the Medical Center recorded a liability of $13,252,269 and $12,520,618, respectively, related to estimated professional liability losses covered under this policy. At September 30, 2019 and 2018, the Medical Center also recorded a receivable of $9,584,019 and $8,829,118, respectively, related to estimated recoveries under insurance coverage for recoveries of the potential losses. These amounts are included in accrued pension and other liabilities, and intangible assets and other, respectively, on the balance sheets.

Workers' Compensation

The Medical Center maintains workers' compensation insurance under a self-insured plan. The plan offers, among other provisions, certain specific and aggregate stop-loss coverage to protect the Medical Center against excessive losses. The Medical Center has employed independent actuaries to estimate the ultimate costs, if any, of the settlement of such claims. Accrued workers' compensation losses of $3,069,898 and $3,061,261 at September 30, 2019 and 2018, respectively, have been discounted at 1.25% and, in management's opinion, provide an adequate reserve for loss contingencies. At September 30, 2019, $1,397,510 and $1,672,388 is recorded within accounts payable and accrued expenses and accrued pension and other liabilities, respectively, in the accompanying balance sheets. The Medical Center has also recorded $258,107 and $408,034 within other current assets and intangible assets and other, respectively, in the accompanying balance sheets to limit the accrued losses to the retention amount at September 30, 2019. At September 30, 2018, $1,359,646 and $1,701,615 is recorded within accounts payable and accrued expenses and accrued pension and other liabilities, respectively, in the accompanying balance sheets. The Medical Center has also recorded $248,403 and $408,513 within other current assets and intangible assets and other, respectively, in the accompanying balance sheets to limit the accrued losses to the retention amount at September 30, 2018.

2. Significant Accounting Policies (Continued)

Health Insurance

The Medical Center has a self-funded health insurance plan. The plan is administered by an insurance company and the Medical Center has employed independent actuaries to estimate unpaid claims, and those claims incurred but not reported at fiscal year end. The Medical Center was insured above a stop-loss amount of $570,000 and $375,000 at September 30, 2019 and 2018, respectively, on individual claims. Estimated unpaid claims, and those claims incurred but not reported, at September 30, 2019 and 2018 of $2,334,000 and $2,849,427, respectively, are reflected in the accompanying balance sheets within accounts payable and accrued expenses.

Functional Expense Allocation

The costs of providing program services and other activities have been summarized on a functional basis in Note 11. Accordingly, costs have been allocated among program services and supporting services benefitted.

Advertising Costs

The Medical Center expenses advertising costs as incurred, and such costs totaled approximately $1,298,000 and $1,716,000 for the years ended September 30, 2019 and 2018, respectively.

Recent Accounting Pronouncements

In August 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2016-14, *Not-for-Profit Entities (Topic 958)* (ASU 2016-14) – *Presentation of Financial Statements of Not-for-Profit Entities*. The update addresses the complexity and understandability of net asset classification, deficiencies in information about liquidity and availability of resources, and the lack of consistency in the type of information provided about expenses and investment return. ASU 2016-14 is effective for the Medical Center for the year ended September 30, 2019. The Medical Center has adjusted the presentation of these financial statements and related disclosures accordingly. ASU 2016-14 has been applied retrospectively to all periods presented. The adoption of ASU 2016-14 had no impact to changes in net assets or total net assets in 2019 or 2018.

In May 2014, the FASB issued ASU No. 2014-09, *Revenue from Contracts with Customers* (ASU 2014-09), which requires revenue to be recognized when promised goods or services are transferred to customers in amounts that reflect the consideration to which the Medical Center expects to be entitled in exchange for those goods and services. ASU 2014-09 will replace most existing revenue recognition guidance in U.S. GAAP when it becomes effective. ASU 2014-09 is effective for the Medical Center on October 1, 2019. ASU 2014-09 permits the use of either the retrospective or cumulative effect transition method. The Medical Center is evaluating the impact that ASU 2014-09 will have on its revenue recognition policies, but does not expect the new pronouncement will have a material impact on its financial statements.

2. Significant Accounting Policies (Continued)

In January 2016, the FASB issued ASU No. 2016-01, *Financial Instruments – Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities* (ASU 2016-01). The amendments in ASU 2016-01 address certain aspects of recognition, measurement, presentation and disclosure of financial instruments. ASU 2016-01 is effective for the Medical Center for the year ended September 30, 2020, with early adoption permitted. The Medical Center is currently evaluating the impact that ASU 2016-01 will have on its financial statements.

In February 2016, the FASB issued ASU No. 2016-02, *Leases (Topic 842)* (ASU 2016-02). Under ASU 2016-02, at the commencement of a long-term lease, lessees will recognize a liability equivalent to the discounted payments due under the lease agreement, as well as an offsetting right-of-use asset. ASU 2016-02 is effective for the Medical Center on October 1, 2021, with early adoption permitted. Lessees (for capital and operating leases) must apply a modified retrospective transition approach for leases existing at, or entered into after, the beginning of the earliest comparative period presented in the financial statements. The modified retrospective approach would not require any transition accounting for leases that expired before the earliest comparative period presented. Lessees may not apply a full retrospective transition approach. The Medical Center is currently evaluating the impact of the pending adoption of ASU 2016-02 on the Medical Center's financial statements.

In November 2016, the FASB issued ASU No. 2016-18, *Statement of Cash Flows (Topic 230): Restricted Cash (a consensus of the FASB Emerging Issues Task Force)* (ASU 2016-18), which provides guidance on the presentation of restricted cash or restricted cash equivalents in the statement of cash flows. ASU 2016-18 will be effective for the Medical Center's fiscal year ended September 30, 2020, and early adoption is permitted. ASU 2016-18 must be applied using a retrospective transition method. The Medical Center is currently evaluating the impact of the adoption of this guidance on its financial statements.

In June 2018, the FASB issued ASU No. 2018-08, *Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made* (ASU 2018-08). Due to diversity in practice, ASU 2018-08 clarifies the definition of an exchange transaction as well as the criteria for evaluating whether contributions are unconditional or conditional. ASU 2018-08 is effective for the Medical Center on October 1, 2019, with early adoption permitted. The Medical Center is currently evaluating the impact that ASU 2018-08 will have on its financial statements.

In August 2018, the FASB issued ASU 2018-13, *Fair Value Measurement (Topic 820): Disclosure Framework – Changes to the Disclosure Requirements for Fair Value Measurement* (ASU 2018-13). The amendments in this ASU modify the disclosure requirements for fair value measurements for Level 3 assets and liabilities, and eliminate the requirement to disclose transfers between Levels 1 and 2 of the fair value hierarchy, among other modifications. ASU 2018-13 is effective for the Medical Center on October 1, 2020, with early adoption permitted. The Medical Center is currently evaluating the impact that ASU 2018-13 will have on its financial statements.

Subsequent Events

Management of the Medical Center evaluated events occurring between the end of the Medical Center's fiscal year and February 4, 2020, the date the financial statements were available to be issued.

3. Financial Assets and Liquidity Resources

Financial assets and liquidity resources available within one year for general expenditure, such as operating expenses, scheduled principal payments on debt, and capital construction costs consisted of the following at September 30, 2019:

Cash and cash equivalents	$ 47,897,010
Short-term investments	4,021,270
Accounts receivable	78,067,491
	$129,985,771

To manage liquidity, the Medical Center maintains sufficient cash and cash equivalent balances to support daily operations throughout the year. Cash and cash equivalents include bank deposits, money market funds, and other similar vehicles that generate a return on cash and provide daily liquidity to the Medical Center. In addition, the Medical Center has board-designated assets that can be utilized at the discretion of management to help fund both operational needs and/or capital projects. As of September 30, 2019, the balance in board-designated assets was approximately $103 million.

4. Net Patient Service Revenue

The following summarizes net patient service revenue for the years ended September 30:

	2019	2018
Gross patient service revenue	$1,401,201,814	$1,309,372,108
Less contractual allowances	(951,717,727)	(873,014,411)
Less provision for doubtful accounts	(20,972,163)	(19,593,714)
Net patient service revenue	$ 428,511,924	$ 416,763,983

The Medical Center maintains contracts with the Social Security Administration ("Medicare") and the State of New Hampshire Department of Health and Human Services ("Medicaid"). The Medical Center is paid a prospectively determined fixed price for each Medicare and Medicaid inpatient acute care service depending on the type of illness or the patient's diagnosis related group classification. Capital costs and certain Medicare and Medicaid outpatient services are also reimbursed on a prospectively determined fixed price. The Medical Center receives payment for other Medicaid outpatient services on a reasonable cost basis which are settled with retroactive adjustments upon completion and audit of related cost finding reports.

Differences between amounts previously estimated and amounts subsequently determined to be recoverable or payable are included in net patient service revenues in the year that such amounts become known. The percentage of net patient service revenues earned from the Medicare and Medicaid programs was 38% and 5%, respectively, for the year ended September 30, 2019 and 39% and 5%, respectively, for the year ended September 30, 2018.

4. Net Patient Service Revenue (Continued)

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The Medical Center believes that it is in compliance with all applicable laws and regulations; compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs (Note 15).

The Medical Center also maintains contracts with certain commercial carriers, health maintenance organizations, preferred provider organizations and state and federal agencies. The basis for payment under these agreements includes prospectively determined rates per discharge and per day, discounts from established charges and fee screens. The Medical Center does not currently hold reimbursement contracts which contain financial risk components.

The approximate percentages of patient service revenues, net of contractual allowances and discounts and provision for doubtful accounts from third-party payors and uninsured patients, are as follows for the years ended September 30:

	Third-Party Payors	Uninsured Patients	Total All Payors
2019			
Net patient service revenues, net of contractual allowance and discounts	99.5%	0.5%	100.0%
2018			
Net patient service revenues, net of contractual allowance and discounts	99.6%	0.4%	100.0%

An estimated breakdown of patient service revenues, net of contractual allowances, discounts and provision for doubtful accounts recognized, is as follows for the years ended September 30 from major payor sources:

	Gross Patient Service Revenues	Contractual Allowances and Discounts	Provision for Doubtful Accounts	Net Patient Service Revenues Less Provision for Doubtful Accounts
2019				
Private payors (includes coinsurance and deductibles)	$ 507,590,533	$(255,769,398)	$ (7,335,140)	$ 244,485,995
Medicaid	147,565,016	(126,294,392)	(258,587)	21,012,037
Medicare	712,776,609	(548,836,484)	(3,196,353)	160,743,772
Self-pay	33,269,656	(20,817,453)	(10,182,083)	2,270,120
	$1,401,201,814	$(951,717,727)	$(20,972,163)	$ 428,511,924

4. Net Patient Service Revenue (Continued)

	Gross Patient Service Revenues	Contractual Allowances and Discounts	Provision for Doubtful Accounts	Net Patient Service Revenues Less Provision for Doubtful Accounts
2018				
Private payors (includes coinsurance and deductibles)	$ 460,815,614	$(221,115,162)	$ (8,909,152)	$ 230,791,300
Medicaid	134,155,231	(111,760,430)	(579,838)	21,814,963
Medicare	684,086,037	(518,673,771)	(2,876,172)	162,536,094
Self-pay	30,315,226	(21,465,048)	(7,228,552)	1,621,626
	$1,309,372,108	$(873,014,411)	$(19,593,714)	$ 416,763,983

The Medical Center recognizes changes in accounting estimates for net patient service revenues and third-party payor settlements as new events occur or as additional information is obtained. For the year ended September 30, 2019, there were no significant adjustments recorded for changes to prior year estimates. For the year ended September 30, 2018, favorable adjustments recorded for changes to prior year estimates were approximately $1,000,000.

Medicaid Enhancement Tax and Disproportionate Share Payment

Under the State of New Hampshire's (the State) tax code, the State imposes a Medicaid Enhancement Tax (MET) equal to 5.40% of the Medical Center's net patient service revenues, with certain exclusions. The amount of tax incurred by the Medical Center for the years ended September 30, 2019 and 2018 was $21,382,132 and $19,968,497, respectively.

In the fall of 2010, in order to remain in compliance with stated federal regulations, the State of New Hampshire adopted a new approach related to Medicaid disproportionate share funding (DSH) retroactive to July 1, 2010. Unlike the former funding method, the State's approach led to a payment that was not directly based on, and did not equate to, the level of tax imposed. As a result, the legislation created some level of losses at certain New Hampshire hospitals, while other hospitals realized gains. DSH payments from the State are recorded in operating revenues and amounted to $22,566,094 and $17,993,289 for the years ended September 30, 2019 and 2018, respectively, net of reserves referenced below.

The Centers for Medicare and Medicaid Services (CMS) has completed audits of the State's program and the disproportionate share payments made by the State from 2011 through 2014, the first years that those payments reflected the amount of uncompensated care provided by New Hampshire hospitals. It is possible that subsequent years will also be audited by CMS. The Medical Center has recorded reserves to address its potential exposure based on the audit results to date or any future redistributions. During 2019, the Medical Center reduced the recorded reserves by approximately $4,300,000.

5. Property, Plant and Equipment

The major categories of property, plant and equipment are as follows at September 30:

	Useful Lives	2019	2018
Land and land improvements	2-40 years	$ 1,472,137	$ 855,991
Buildings and improvements	2-40 years	106,435,085	97,791,941
Fixed equipment	3-25 years	45,218,504	44,759,299
Movable equipment	3-25 years	153,057,048	137,026,708
Construction in progress		8,002,406	9,259,588
		314,185,180	289,693,527
Less accumulated depreciation and amortization		(195,495,104)	(179,795,294)
Net property, plant and equipment		$ 118,690,076	$ 109,898,233

Depreciation expense amounted to $15,699,810 and $14,928,402 for the years ended September 30, 2019 and 2018, respectively.

The cost of equipment under capital leases was $7,844,527 at September 30, 2019 and 2018. Accumulated amortization of the leased equipment at September 30, 2019 and 2018 was $7,691,462 and $7,059,231, respectively. Amortization of assets under capital leases is included in depreciation and amortization expense.

6. Long-Term Debt and Note Payable

Long-term debt consists of the following at September 30:

	2019	2018
New Hampshire Health and Education Facilities Authority (the Authority) Revenue Bonds:		
Series 2012 Bonds with interest ranging from 4.00% to 5.00% per year and principal payable in annual installments ranging from $1,125,000 to $2,755,000 through July 2032	$ 19,800,000	$ 22,450,000
Series 2015A Bonds with interest at a fixed rate of 2.27% per year and principal payable in annual installments ranging from $185,000 to $1,655,000 through July 2040	21,650,000	22,255,000
Series 2015B with variable interest subject to interest rate swap described below and principal payable in annual installments ranging from $195,000 to $665,000 through July 2036	8,060,000	8,260,000
Series 2017 Bonds with interest ranging from 3.38% to 5.00% per year and principal payable in annual installments ranging from $2,900,000 to $7,545,000 beginning in July 2033 through July 2044	61,115,000	61,115,000
	110,625,000	114,080,000

6. Long-Term Debt and Note Payable (Continued)

	2019	2018
Construction loan – see below	$ 3,513,632	$ –
Capitalized lease obligations	344,079	1,020,278
Unamortized original issue premiums/discounts	5,057,437	5,450,325
Unamortized debt issuance costs	(1,194,718)	(1,190,075)
	118,345,430	119,360,528
Less current portion	(3,924,079)	(4,131,199)
	$114,421,351	$115,229,329

The Authority Revenue Bonds

In December 2012, the Medical Center, in connection with the Authority, issued $35,275,000 of tax-exempt fixed rate revenue bonds (Series 2012). Under the terms of the loan agreements, the Medical Center has granted the Authority a first collateralized interest in all gross receipts and a mortgage lien on existing and future property, plant and equipment. The Medical Center is required to maintain a minimum debt service coverage ratio of 1.20. The Medical Center was in compliance with this covenant as of September 30, 2019. The proceeds of the Series 2012 bond issue were used to advance refund the remaining 2002A Bonds, advance refund certain 2002B Bonds, pay off a short term CAN note and fund certain capital purchases.

On September 3, 2015, the Authority issued $32,720,000 of Revenue Bonds, Catholic Medical Center Issue, Series 2015, consisting of the $24,070,000 aggregate principal amount Series 2015A Bonds and the $8,650,000 aggregate principal amount Series 2015B Bonds sold via direct placement to a financial institution. Although the Series 2015B Bonds were issued, they were not drawn on until July 1, 2016, as discussed below. Under the terms of the loan agreements, the Medical Center has granted the Authority a first collateralized interest in all gross receipts and a mortgage lien on existing and future property, plant and equipment. The Medical Center is required to maintain a minimum debt service coverage ratio of 1.20. The Medical Center was in compliance with this covenant as of September 30, 2019.

The Series 2015A Bonds were issued to provide funds for the purpose of (i) advance refunding a portion of the outstanding 2006 Bonds in an amount of $20,655,000 to the first call date of July 1, 2016, (ii) funding certain construction projects and equipment purchases in an amount of approximately $3,824,000, and (iii) paying the costs of issuance related to the Series 2015 Bonds.

The Series 2015B Bonds were structured as drawdown bonds. On July 1, 2016, the full amount available under the Series 2015B Bonds totaling $8,650,000 was drawn upon and the proceeds in combination with cash contributed by the Medical Center totaling $555,000 were used to currently refund the remaining balance of the Series 2006 Bonds totaling $9,205,000.

6. Long-Term Debt and Note Payable (Continued)

On September 1, 2017, the Authority issued $61,115,000 of Revenue Bonds, Catholic Medical Center Issue, Series 2017. The Series 2017 Bonds were issued to fund various construction projects and equipment purchases, as well as pay certain costs of issuance related to the Series 2017 Bonds. Under the terms of the loan agreements, the Medical Center has granted the Authority a first collateralized interest in all gross receipts and a mortgage lien on existing and future property, plant and equipment. The Medical Center is required to maintain a minimum debt service coverage ratio of 1.20. The Medical Center was in compliance with this covenant as of September 30, 2019.

The Medical Center has an agreement with the Authority, which provides for the establishment of various funds, the use of which is generally restricted to the payment of debt, as well as a construction fund related to the Series 2017 Bonds. These funds are administered by a trustee, and income earned on certain of these funds is similarly restricted.

Construction Loan

On July 1, 2019, the Medical Center established a nonrevolving line of credit up to $10,000,000 with a bank in order to fund the expansion of the Medical Center as discussed in Note 15. The line of credit bears interest at the LIBOR lending rate plus 0.75% (2.84% at September 30, 2019). Advances from the line of credit are available through July 1, 2021, at which time the then outstanding line of credit balance will automatically convert to a term loan. Upon conversion, the Medical Center shall make monthly payments of principal and interest, assuming a 30-year level monthly principal and interest payment schedule, with a final maturity of July 1, 2029. The bank shall compute the schedule of principal payments based on the interest rate applicable on the conversion date. Payments of interest only are due on a monthly basis until the conversion date. The Medical Center has pledged gross receipts as collateral and is also required to maintain a minimum debt service coverage ratio of 1.20. The Medical Center was in compliance with this covenant as of September 30, 2019. As of September 30, 2019, the Medical Center has drawn $3,513,632 on this line of credit.

The aggregate principal payments due on the revenue bonds, capital lease obligations and other debt obligations for each of the five years ending September 30 and thereafter are as follows:

2020	$ 3,924,079
2021	2,416,886
2022	2,545,704
2023	2,767,881
2024	2,860,120
Thereafter	99,968,041
	$114,482,711

Interest paid by the Medical Center totaled $4,390,413 (including capitalized interest of $158,155) for the year ended September 30, 2019 and totaled $3,926,297 (including capitalized interest of $251,490) for the year ended September 30, 2018.

6. Long-Term Debt and Note Payable (Continued)

The fair value of the Medical Center's long-term debt is estimated using discounted cash flow analysis, based on the Medical Center's current incremental borrowing rate for similar types of borrowing arrangements. The fair value of the Medical Center's long-term debt, excluding capitalized lease obligations, was approximately $120,300,000 and $114,080,000 at September 30, 2019 and 2018, respectively.

On March 27, 2018, the MOB LLC (a subsidiary of Alliance Enterprises, Inc., which is a subsidiary of the System) refinanced an existing note payable to a term loan totaling $8,130,000. Interest is fixed at 3.71% and is payable monthly. Principal payments of $19,500 are due in monthly installments beginning May 1, 2018, continuing until March 27, 2028, at which time the remaining unpaid principal and interest shall be due in full. Under the terms of the loan agreement, the Medical Center and MOB LLC (the Obligated Group) has granted the bank a first collateralized interest in all gross receipts and a mortgage lien on existing and future property, plant and equipment. The Medical Center and the System also guarantee the note payable. The Obligated Group is required to maintain a minimum debt service coverage ratio of 1.20. The Obligated Group was in compliance with this covenant as of September 30, 2019.

Derivatives

The Medical Center uses derivative financial instruments principally to manage interest rate risk. In January 2016, the Medical Center entered into an interest rate swap agreement with an initial notional amount of $8,650,000 in connection with its Series 2015B Bond issuance. The swap agreement hedges the Medical Center's interest exposure by effectively converting interest payments from variable rates to a fixed rate. The swap agreement is designated as a cash flow hedge of the underlying variable rate interest payments, and changes in the fair value of the swap agreement are reported as a change in net assets without donor restrictions. Under this agreement, the Medical Center pays a fixed rate equal to 1.482%, and receives a variable rate of 69.75% of the one-month LIBOR rate (1.46% at September 30, 2019). Payments under the swap agreement began August 1, 2016 and the agreement will terminate August 1, 2025.

The fair value of the Medical Center's interest rate swap agreement amounted to a liability of $220,010 as of September 30, 2019, which amount has been recorded within accrued pension and other liabilities in the accompanying 2019 balance sheet. The fair value of the Medical Center's interest rate swap agreement amounted to an asset of $262,725 as of September 30, 2018, which amount has been recorded within intangible assets and other in the accompanying 2018 balance sheet. The (decrease) increase in the fair value of this derivative of $(482,735) and $302,826, respectively, has been included within the statements of changes in net assets as a change in net assets without donor restrictions for the years ended September 30, 2019 and 2018.

7. Operating Leases

The Medical Center has various noncancelable agreements to lease various pieces of medical equipment. The Medical Center also has noncancelable leases for office space and its physician practices. Certain real estate leases are with related parties. Total rent expense paid to related parties for the years ended September 30, 2019 and 2018 was $2,470,557 and $2,396,723, respectively. Rental expense under all leases for the years ended September 30, 2019 and 2018 was $5,459,713 and $5,371,336, respectively.

Estimated future minimum lease payments under noncancelable operating leases are as follows:

2020	$ 4,341,378
2021	4,392,246
2022	4,452,544
2023	2,447,919
2024	2,428,338
Thereafter	4,534,987
	$22,597,412

8. Investments and Assets Whose Use is Limited

Investments and assets whose use is limited are comprised of the following at September 30:

	2019		2018	
	Fair Value	Cost	Fair Value	Cost
Cash and cash equivalents	$ 16,779,157	$ 16,779,157	$ 16,330,473	$ 16,330,473
U.S. federal treasury obligations	19,045,894	19,043,708	36,950,913	36,957,748
Marketable equity securities	39,052,447	35,856,117	38,360,061	34,394,784
Fixed income securities	36,384,136	36,288,215	55,768,356	56,864,630
Private investment funds	51,796,283	21,653,351	55,530,346	25,886,418
Pledges receivable	758,184	758,184	–	–
	$163,816,101	$130,378,732	$202,940,149	$170,434,053

Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability (an exit price) in the principal or most advantageous market for the asset or liability in an orderly transaction between market participants on the measurement date. In determining fair value, the use of various valuation approaches, including market, income and cost approaches, is permitted.

A fair value hierarchy has been established based on whether the inputs to valuation techniques are observable or unobservable. Observable inputs reflect market data obtained from sources independent of the reporting entity and unobservable inputs reflect the entity's own assumptions about how market participants would value an asset or liability based on the best information available. Valuation techniques used to measure fair value must maximize the use of observable inputs and minimize the use of unobservable inputs. The standard describes a fair value hierarchy based on three levels of inputs, of which the first two are considered observable and the last unobservable, that may be used to measure fair value.

8. Investments and Assets Whose Use is Limited (Continued)

The following describes the hierarchy of inputs used to measure fair value and the primary valuation methodologies used by the Medical Center for financial instruments measured at fair value on a recurring basis. The three levels of inputs are as follows:

Level 1 — Observable inputs such as quoted prices in active markets;

Level 2 — Inputs, other than the quoted prices in active markets, that are observable either directly or indirectly; and

Level 3 — Unobservable inputs in which there is little or no market data.

Assets and liabilities measured at fair value are based on one or more of three valuation techniques. The three valuation techniques are as follows:

- *Market approach* – Prices and other relevant information generated by market transactions involving identical or comparable assets or liabilities;
- *Cost approach* – Amount that would be required to replace the service capacity of an asset (i.e., replacement cost); and
- *Income approach* – Techniques to convert future amounts to a single present amount based on market expectations (including present value techniques).

In determining the appropriate levels, the Medical Center performs a detailed analysis of the assets and liabilities. There have been no changes in the methodologies used at September 30, 2019 and 2018.

The following is a description of the valuation methodologies used:

U.S. Federal Treasury Obligations and Fixed Income Securities

The fair value is determined by using broker or dealer quotations, external pricing providers, or alternative pricing sources with reasonable levels of price transparency. The Medical Center holds fixed income mutual funds and exchange traded funds, governmental and federal agency debt instruments, municipal bonds, corporate bonds, and foreign bonds which are primarily classified as Level 1 within the fair value hierarchy.

Marketable Equity Securities

Marketable equity securities are valued based on stated market prices and at the net asset value of shares held by the Medical Center at year end, which generally results in classification as Level 1 within the fair value hierarchy.

8. Investments and Assets Whose Use is Limited (Continued)

Private Investment Funds

The Medical Center invests in private investment funds that consist primarily of limited partnership interests in investment funds, which, in turn, invest in diversified portfolios predominantly comprised of equity and fixed income securities, as well as options, futures contracts, and some other less liquid investments. Management has approved procedures pursuant to the methods in which the Medical Center values these investments, which ordinarily will be the amount equal to the pro-rata interest in the net assets of the limited partnership, as such value is supplied by, or on behalf of, each investment manager from time to time, usually monthly and/or quarterly.

Medical Center management is responsible for the fair value measurements of investments reported in the financial statements. Such amounts are generally determined using audited financial statements of the funds and/or recently settled transactions. Because of inherent uncertainty of valuation of certain private investment funds, the estimate of the fund manager or general partner may differ from actual values, and differences could be significant. Management believes that reported fair values of its private investment funds at the balance sheet dates are reasonable.

Fair Value on a Recurring Basis

The following table presents information about the Medical Center's assets and liabilities measured at fair value on a recurring basis based upon the lowest level of significant input to the valuations at September 30.

	Level 1	Level 2	Level 3	Total
2019				
Assets				
Cash and cash equivalents	$ 16,779,157	$ –	$ –	$ 16,779,157
U.S. federal treasury obligations	19,045,894	–	–	19,045,894
Marketable equity securities	39,052,447	–	–	39,052,447
Fixed income securities	36,384,136	–	–	36,384,136
Pledges receivable	–	–	758,184	758,184
	$111,261,634	$ –	$758,184	112,019,818
Investments measured at net asset value:				
Private investment funds				51,796,283
Total assets at fair value				$163,816,101
Liabilities				
Interest rate swap agreement	$ –	$ –	$220,010	$ 220,010

8. Investments and Assets Whose Use is Limited (Continued)

	Level 1	Level 2	Level 3	Total
2018				
Assets				
Cash and cash equivalents	$ 16,330,473	$ –	$ –	$ 16,330,473
U.S. federal treasury obligations	36,950,913	–	–	36,950,913
Marketable equity securities	38,360,061	–	–	38,360,061
Fixed income securities	55,768,356	–	–	55,768,356
Interest rate swap agreement	–	–	262,725	262,725
	$147,409,803	$ –	$262,725	147,672,528
Investments measured at net asset value:				
Private investment funds				55,530,346
Total assets at fair value				$203,202,874

The following table presents the assets (liabilities) carried at fair value as of September 30, 2019 and 2018 that are classified within Level 3 of the fair value hierarchy.

	Pledges Receivable
Balance at September 30, 2018	$ –
Net activity	758,184
Balance at September 30, 2019	$ 758,184

	Interest Rate Swap Agreement
Balance at September 30, 2017	$ (40,101)
Unrealized gains	302,826
Balance at September 30, 2018	262,725
Unrealized losses	(482,735)
Balance at September 30, 2019	$(220,010)

There were no significant transfers between Levels 1, 2 or 3 for the years ended September 30, 2019 or 2018.

8. Investments and Assets Whose Use is Limited (Continued)

Net Asset Value Per Share

The following table discloses the fair value and redemption frequency of those assets whose fair value is estimated using the net asset value per share practical expedient at September 30:

Category	Fair Value	Unfunded Commitments	Redemption Frequency	Notice Period
2019				
Private investment funds	$48,155,175	$ –	Daily/monthly	2-30 day notice
Private investment funds	3,641,108	–	Quarterly	30 day notice
2018				
Private investment funds	$52,108,790	$ –	Daily/monthly	2-30 day notice
Private investment funds	3,421,556	–	Quarterly	30 day notice

Investment Strategies

U.S. Federal Treasury Obligations and Fixed Income Securities

The primary purpose of these investments is to provide a highly predictable and dependable source of income, preserve capital, reduce the volatility of the total portfolio, and hedge against the risk of deflation or protracted economic contraction.

Marketable Equity Securities

The primary purpose of equity investments is to provide appreciation of principal and growth of income with the recognition that this requires the assumption of greater market volatility and risk of loss. The total equity portion of the portfolio will be broadly diversified according to economic sector, industry, number of holdings and other characteristics, including style and capitalization. The Medical Center may employ multiple equity investment managers, each of whom may have distinct investment styles. Accordingly, while each manager's portfolio may not be fully diversified, it is expected that the combined equity portfolio will be broadly diversified.

Private Investment Funds

The primary purpose of private investment funds is to provide further portfolio diversification and to reduce overall portfolio volatility by investing in strategies that are less correlated with traditional equity and fixed income investments. Private investment funds may provide access to strategies otherwise not accessible through traditional equities and fixed income such as derivative instruments, real estate, distressed debt and private equity and debt.

8. Investments and Assets Whose Use is Limited (Continued)

Fair Value of Other Financial Instruments

Other financial instruments consist of accounts receivable, accounts payable and accrued expenses, amounts payable to third-party payors and long-term debt. The fair value of all financial instruments other than long-term debt approximates their relative book values as these financial instruments have short-term maturities or are recorded at amounts that approximate fair value. See Note 6 for disclosure of the fair value of long-term debt.

9. Retirement Benefits

As previously discussed in Note 2, the Plan provides retirement benefits for certain employees of an affiliated organization. The disclosure below provides information for the Plan as a whole. A reconciliation of the changes in the Catholic Medical Center Pension Plan and the Medical Center's Supplemental Executive Retirement Plan projected benefit obligations and the fair value of assets for the years ended September 30, 2019 and 2018, and a statement of funded status of the plans for both years is as follows:

	Catholic Medical Center Pension Plan		Pre-1987 Supplemental Executive Retirement Plan	
	2019	2018	2019	2018
Changes in benefit obligations:				
Projected benefit obligations at beginning of year	$ (270,114,507)	$ (284,200,778)	$ (4,140,755)	$ (4,567,286)
Service cost	(1,500,000)	(1,500,000)	–	–
Interest cost	(11,301,910)	(10,628,197)	(154,744)	(140,414)
Benefits paid	7,935,050	7,117,759	408,853	411,692
Actuarial (loss) gain	(48,841,695)	17,666,264	(174,264)	155,253
Expenses paid	1,468,125	1,430,445	–	–
Projected benefit obligations at end of year	(322,354,937)	(270,114,507)	(4,060,910)	(4,140,755)
Changes in plan assets:				
Fair value of plan assets at beginning of year	185,414,590	181,485,201	–	–
Actual return on plan assets	5,194,931	12,074,468	–	–
Employer contributions	8,141,191	403,125	408,853	411,692
Benefits paid	(7,935,050)	(7,117,759)	(408,853)	(411,692)
Expenses paid	(1,468,125)	(1,430,445)	–	–
Fair value of plan assets at end of year	189,347,537	185,414,590	–	–
Funded status of plan at September 30	$ (133,007,400)	$ (84,699,917)	$ (4,060,910)	$ (4,140,755)

9. Retirement Benefits (Continued)

	Catholic Medical Center Pension Plan		Pre-1987 Supplemental Executive Retirement Plan	
	2019	2018	2019	2018
Amounts recognized in the balance sheets consist of:				
Current liability	$ –	$ –	$ (391,100)	$ (398,750)
Noncurrent liability	(133,007,400)	(84,699,917)	(3,669,810)	(3,742,005)
	$(133,007,400)	$ (84,699,917)	$(4,060,910)	$ (4,140,755)

The net loss for the defined benefit pension plans that will be amortized from net assets without donor restrictions into net periodic benefit cost over the next fiscal year is $4,607,147.

The current portion of accrued pension costs included in the above amounts for the Medical Center amounted to $391,100 and $398,750 at September 30, 2019 and 2018, respectively, and has been included in accounts payable and accrued expenses in the accompanying balance sheets.

The amounts recognized in net assets without donor restrictions for the years ended September 30 consist of:

	Catholic Medical Center Pension Plan		Pre-1987 Supplemental Executive Retirement Plan	
	2019	2018	2019	2018
Amounts recognized in the balance sheets – total plan:				
Net assets without donor restrictions:				
Net loss	$(160,478,700)	$(105,860,712)	$(2,141,585)	$ (2,102,034)
	$(160,478,700)	$(105,860,712)	$(2,141,585)	$ (2,102,034)

Net periodic pension cost includes the following components for the years ended September 30:

	Catholic Medical Center Pension Plan		Pre-1987 Supplemental Executive Retirement Plan	
	2019	2018	2019	2018
Service cost	$ 1,500,000	$ 1,500,000	$ –	$ –
Interest cost	11,301,910	10,628,197	154,744	140,414
Expected return on plan assets	(13,738,629)	(13,110,637)	–	–
Amortization of actuarial loss	2,767,405	3,275,000	134,713	147,466
Net periodic pension cost	$ 1,830,686	$ 2,292,560	$289,457	$ 287,880

9. Retirement Benefits (Continued)

Other changes in plan assets and benefit obligations recognized in net assets without donor restrictions for the years ended September 30 consist of:

	Catholic Medical Center Pension Plan		Pre-1987 Supplemental Executive Retirement Plan	
	2019	2018	2019	2018
Net loss (gain)	$57,388,232	$(16,630,095)	$ 174,264	$ (155,253)
Amortization of actuarial loss	(2,767,405)	(3,275,000)	(134,713)	(147,466)
Net amount recognized	$54,620,827	$(19,905,095)	$ 39,551	$ (302,719)

The investments of the plans are comprised of the following at September 30:

	Target Allocation		Catholic Medical Center Pension Plan	
	2019	2018	2019	2018
Cash and cash equivalents	5.0%	0.0%	3.5%	1.1%
Equity securities	65.0	70.0	68.5	66.2
Fixed income securities	20.0	20.0	24.6	23.7
Other	10.0	10.0	3.4	9.0
	100.0%	100.0%	100.0%	100.0%

The assumption for the long-term rate of return on plan assets has been determined by reflecting expectations regarding future rates of return for the investment portfolio, with consideration given to the distribution of investments by asset class and historical rates of return for each individual asset class.

The weighted-average assumptions used to determine the defined benefit pension plan obligations at September 30 are as follows:

	Catholic Medical Center Pension Plan		Pre-1987 Supplemental Executive Retirement Plan	
	2019	2018	2019	2018
Discount rate	3.12%	4.23%	2.70%	3.93%
Rate of compensation increase	N/A	N/A	N/A	N/A

9. Retirement Benefits (Continued)

The weighted-average assumptions used to determine the defined benefit pension plan net periodic benefit costs for the years ended September 30 are as follows:

	Catholic Medical Center Pension Plan		Pre-1987 Supplemental Executive Retirement Plan	
	2019	2018	2019	2018
Discount rate	4.23%	3.79%	3.93%	3.22%
Rate of compensation increase	N/A	N/A	N/A	N/A
Expected long-term return on plan assets	7.30%	7.30%	N/A	N/A

The Medical Center expects to make employer contributions totaling $6,500,000 to the Catholic Medical Center Pension Plan for the fiscal year ending September 30, 2020. Expected employer contributions to the Pre-1987 Supplemental Executive Retirement Plan for the fiscal year ending September 30, 2020 are not expected to be significant.

The benefits, which reflect expected future service, as appropriate, expected to be paid for the years ending September 30 are as follows:

	Catholic Medical Center Pension Plan	Pre-1987 Supplemental Executive Retirement Plan
2020	$ 9,243,136	$ 396,345
2021	9,993,328	381,634
2022	10,827,746	366,382
2023	11,705,953	350,590
2024	12,473,696	334,272
2025 - 2029	72,831,683	1,409,626

The Medical Center contributed $8,141,191 and $408,853 to the Catholic Medical Center Pension Plan and the Pre-1987 Supplemental Executive Retirement Plan, respectively, for the year ended September 30, 2019. The Medical Center contributed $403,125 and $411,692 to the Catholic Medical Center Pension Plan and the Pre-1987 Supplemental Executive Retirement Plan, respectively, for the year ended September 30, 2018. The Medical Center plans to make any necessary contributions during the upcoming fiscal 2020 year to ensure the plans continue to be adequately funded given the current market conditions.

9. Retirement Benefits (Continued)

The following fair value hierarchy table presents information about the financial assets of the above plans measured at fair value on a recurring basis based upon the lowest level of significant input valuation as of September 30:

	Level 1	Level 2	Level 3	Total
2019				
Cash and cash equivalents	$ 6,533,857	$ –	$ –	$ 6,533,857
Marketable equity securities	48,189,852	–	–	48,189,852
Fixed income securities	46,506,391	–	–	46,506,391
	$101,230,100	$ –	$ –	101,230,100
Investments measured at net asset value:				
Private investment funds				88,117,437
Total assets at fair value				$189,347,537
2018				
Cash and cash equivalents	$ 2,135,972	$ –	$ –	$ 2,135,972
Marketable equity securities	38,773,946	–	–	38,773,946
Fixed income securities	43,989,255	–	–	43,989,255
	$ 84,899,173	$ –	$ –	84,899,173
Investments measured at net asset value:				
Private investment funds				100,515,417
Total assets at fair value				$185,414,590

10. Related Party Transactions

During 2019 and 2018, the Medical Center made and received transfers of net assets (to) from affiliated organizations as follows:

	2019	2018
Alliance Health Services	$ (5,650,000)	$ (4,130,000)
Physician Practice Associates	(42,163,000)	(31,967,000)
Alliance Ambulatory Service	2,500,000	1,650,000
Alliance Resources	(700,000)	(1,092,878)
NH Medical Laboratory	(120,167)	(42,936)
Saint Peter's Home	(477)	(10)
MOB LLC	–	(200,000)
	$ (46,133,644)	$ (35,782,824)

10. Related Party Transactions (Continued)

The Medical Center entered into various other transactions with the aforementioned related organizations. The net effect of these transactions was an amount due to affiliates of $991,062 and $1,477,267 at September 30, 2019 and 2018, respectively. See Note 7 for related party leasing activity.

The Medical Center has engaged in various transactions with GraniteOne, HH and MCH. The Medical Center recognized approximately $3.3 million and $3.4 million in revenue from these related parties for the years ended September 30, 2019 and 2018, respectively, which is reflected within other revenues in the accompanying statements of operations. The Medical Center also incurred expenses to these related parties of approximately $2.5 million and $399,000 for the years ended September 30, 2019 and 2018, respectively, of which $800,000 and $399,000, respectively, is reflected within operating expenses. Additionally, approximately $1.7 million as of September 30, 2019, is reflected within nonoperating gains (losses) in the accompanying statement of operations for the year ended September 30, 2019. As of September 30, 2019, the Medical Center had a net amount due from these related parties of approximately $2.6 million, of which $4.4 million is reflected within other current assets and $1.8 million is reflected within accounts payable and accrued expenses in the accompanying 2019 balance sheet. As of September 30, 2018, the Medical Center has a net amount due from these related parties of approximately $507,000, which is reflected within other current assets in the accompanying 2018 balance sheet.

11. Functional Expenses

The Medical Center provides general health care services to residents within its geographic location including inpatient, outpatient and emergency care. Expenses related to providing these services are as follows at September 30, 2019:

	Healthcare Services	General and Administrative	Total
Salaries, wages and fringe benefits	$188,050,439	$39,509,036	$227,559,475
Supplies and other	129,874,004	31,408,147	161,282,151
New Hampshire Medicaid enhancement tax	21,382,132	–	21,382,132
Depreciation and amortization	10,590,236	5,151,583	15,741,819
Interest	3,178,047	735,888	3,913,935
	$353,074,858	$76,804,654	$429,879,512

For the year ended September 30, 2018, the Medical Center provided $332,542,503 in health services expenses and $77,727,536 in general and administrative expenses.

The financial statements report certain expense categories that are attributable to more than one healthcare service or support function. Therefore, these expenses require an allocation on a reasonable basis that is consistently applied. Costs not directly attributable to a function, such as depreciation and interest, are allocated to a function based on square footage. Supporting activities that are not directly identifiable with one or more healthcare programs are classified as general and administrative. If it is impossible or impractical to make a direct identification, allocation of the expenses were made according to management's estimates. Employee benefits are allocated in accordance with the ratio of salaries and wages of the functional classes. Specifically identifiable costs are assigned to the function which they are identified to.

12. Concentration of Credit Risk

The Medical Center grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors is as follows at September 30:

	2019	2018
Medicare	45%	44%
Medicaid	12	13
Commercial insurance and other	25	23
Patients (self pay)	5	8
Anthem Blue Cross	13	12
	100%	100%

13. Endowments and Net Assets With Donor Restrictions

Endowments

In July 2008, the State of New Hampshire enacted a version of UPMIFA (the Act). The new law, which had an effective date of July 1, 2008, eliminates the historical dollar threshold and establishes prudent spending guidelines that consider both the duration and preservation of the fund. As a result of this enactment, subject to the donor's intent as expressed in a gift agreement or similar document, a New Hampshire charitable organization may now spend the principal and income of an endowment fund, even from an underwater fund, after considering the factors listed in the Act.

Endowment net assets consist of the following at September 30:

	Without Donor Restrictions	With Donor Restrictions	Total
2019			
Board-designated endowment funds	$102,949,965	$ –	$102,949,965
Donor-restricted endowment funds:			
Original donor-restricted gift amount and amounts required to be maintained in perpetuity by donor	–	7,342,731	7,342,731
Accumulated investment gains	–	2,902,160	2,902,160
Total endowment net assets	$102,949,965	$10,244,891	$113,194,856

13. Endowments and Net Assets With Donor Restrictions (Continued)

	Without Donor Restrictions	With Donor Restrictions	Total
2018			
Board-designated endowment funds	$ 99,976,116	$ –	$ 99,976,116
Donor-restricted endowment funds:			
Original donor-restricted gift amount and amounts required to be maintained in perpetuity by donor	–	7,342,731	7,342,731
Accumulated investment gains	–	3,084,087	3,084,087
Total endowment net assets	$ 99,976,116	$10,426,818	$110,402,934

Changes in endowment net assets consisted of the following for the years ended September 30:

	Without Donor Restrictions	With Donor Restrictions	Total
Balance at September 30, 2017	$ 94,579,515	$ 9,726,007	$104,305,522
Investment return, net	5,268,001	430,243	5,698,244
Contributions	–	646,924	646,924
Appropriation for operations	–	(247,756)	(247,756)
Appropriation for capital	128,600	(128,600)	–
Balance at September 30, 2018	99,976,116	10,426,818	110,402,934
Investment return, net	2,539,839	(63,353)	2,476,486
Contributions	–	536,316	536,316
Appropriation for operations	–	(220,880)	(220,880)
Appropriation for capital	434,010	(434,010)	–
Balance at September 30, 2019	$102,949,965	$10,244,891	$113,194,856

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor requires the Medical Center to retain as a fund of perpetual duration. There were no such deficiencies as of September 30, 2019 or 2018.

13. Endowments and Net Assets With Donor Restrictions (Continued)

Net Assets With Donor Restrictions

Net assets with donor restrictions are available for the following purposes at September 30:

	2019	2018
Funds subject to use or time restrictions:		
Capital acquisitions	$ 258,494	$ 37,941
Health education	909,765	899,288
Indigent care	168,437	253,492
Pledges receivable	758,184	–
	2,094,880	1,190,721
Funds of perpetual duration	9,150,011	9,236,097
	$11,244,891	$10,426,818

14. Investments in Joint Venture

The Medical Center, along with four other participating hospitals and Tufts Health Plan, formed Tufts Health Freedom Plan (THFP), a joint venture. THFP is a health insurance company which began operations as of January 1, 2016. The Medical Center has an approximate 12% ownership interest in this joint venture. Selected financial information relating to this joint venture for the years ended September 30, 2019 and 2018 is not shown as such amounts are not significant to the financial statements.

15. Commitments and Contingencies

Litigation

Various legal claims, generally incidental to the conduct of normal business, are pending or have been threatened against the Medical Center. The Medical Center intends to defend vigorously against these claims. While ultimate liability, if any, arising from any such claim is presently indeterminable, it is management's opinion that the ultimate resolution of these claims will not have a material adverse effect on the financial condition of the Medical Center.

Regulatory

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. Government activity continues with respect to investigations and allegations concerning possible violations by health care providers of fraud and abuse statutes and regulations, which could result in the imposition of significant fines and penalties as well as significant repayments for patient services previously billed. Compliance with such laws and regulations are subject to government review and interpretations as well as regulatory actions unknown or unasserted at this time.

15. Commitments and Contingencies (Continued)

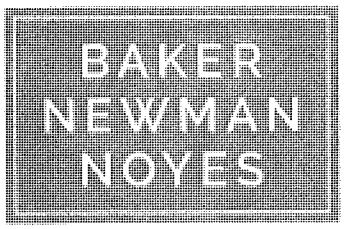
Development Agreement

During fiscal year 2019, the Medical Center entered into a development agreement with PJC Manchester Realty, LLC ("Rite Aid") in regards to the Medical Center's acquisition of certain property owned by Rite Aid. Under the development agreement, the Medical Center acquired the property from Rite Aid for approximately $6.9 million, inclusive of certain costs expected to be incurred to construct a new building that Rite Aid will own and occupy at a separate location. The purchase of the property from Rite Aid allows the Medical Center to expand its campus. As the Medical Center retains title to the project until such time of the second closing, as defined within the development agreement, amounts paid under the development agreement are recorded by the Medical Center as land acquisition costs, and totaled approximately $4.6 million as of September 30, 2019.

The Medical Center has outstanding construction commitments related to this project totaling approximately $8.1 million at September 30, 2019.

Attachment 7

MCH Audited Financial Statements FY 2019



The Monadnock Community Hospital

Audited Financial Statements

Years Ended September 30, 2019 and 2018
With Independent Auditors' Report

Baker Newman & Noyes LLC
MAINE | MASSACHUSETTS | NEW HAMPSHIRE
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THE MONADNOCK COMMUNITY HOSPITAL

Audited Financial Statements

Years Ended September 30, 2019 and 2018

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BAKER NEWMAN NOYES

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INDEPENDENT AUDITORS' REPORT

Board of Trustees
The Monadnock Community Hospital

We have audited the accompanying financial statements of The Monadnock Community Hospital (the Hospital), which comprise the balance sheets as of September 30, 2019 and 2018, and the related statements of operations, changes in net assets and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonablencss of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

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

Board of Trustees
The Monadnock Community Hospital

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Hospital as of September 30, 2019 and 2018, and the results of its operations, changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter

As discussed in Note 1 to the financial statements, in 2019, the Hospital adopted the provisions of Financial Accounting Standards Board Accounting Standards Update (ASU) No. 2016-14, *Not-for-Profit Entities (Topic 958) - Presentation of Financial Statements of Not-for-Profit Entities* and applied the guidance retrospectively for all periods presented. Our opinion is not modified with respect to this matter.

Baker Newman & Noyes LLC

Manchester, New Hampshire
January 21, 2020

THE MONADNOCK COMMUNITY HOSPITAL

BALANCE SHEETS

September 30, 2019 and 2018

ASSETS

	2019	2018
Current assets:		
Cash and cash equivalents	$ 13,442,283	$ 12,271,683
Accounts receivable, net (notes 2 and 4)	8,907,681	9,473,219
Current portion of notes receivable	89,370	164,377
Other receivables (note 10)	641,032	444,154
Current portion of pledges receivable, net (note 5)	95,238	95,923
Inventories	1,326,143	1,410,000
Prepaid expenses	1,018,003	1,103,571
Total current assets	25,519,750	24,962,927
Assets limited as to use (notes 4, 6, 9 and 16)	73,735,389	67,523,029
Medical office building and related assets, net of accumulated depreciation of $2,170,183 in 2019 and $2,075,186 in 2018	1,249,441	1,344,438
Property and equipment, net (notes 7 and 8)	35,990,025	35,905,953
Notes receivable, less current portion	15,371	37,215
Other:		
Pledges receivable, less current portion, net (note 5)	95,070	199,735
Other assets	202,383	197,968
	297,453	397,703
Total assets	$136,807,429	$130,171,265

LIABILITIES AND NET ASSETS

	2019	2018
Current liabilities:		
Accounts payable and accrued expenses	$ 7,417,770	$ 6,631,553
Accrued payroll and amounts withheld	2,234,302	2,197,969
Estimated third-party payor settlements (note 3)	19,551,812	17,828,486
Current portion of long-term debt and capital lease obligations	777,725	717,483
Total current liabilities	29,981,609	27,375,491
Long-term debt and capital lease obligations, less current portion (note 8)	23,550,598	23,704,690
Interest rate swap agreements (notes 8 and 16)	3,028,761	1,177,576
Total liabilities	56,560,968	52,257,757
Commitments and contingencies (note 12)		
Net assets:		
Without donor restrictions	66,538,580	64,496,464
With donor restrictions (note 9)	13,707,881	13,417,044
Total net assets	80,246,461	77,913,508
Total liabilities and net assets	$136,807,429	$130,171,265

See accompanying notes.

THE MONADNOCK COMMUNITY HOSPITAL

STATEMENTS OF OPERATIONS

Years Ended September 30, 2019 and 2018

	2019	2018
Unrestricted revenue and other support:		
Net patient service revenue, net of contractual allowances and discounts, before disproportionate share funding (notes 3 and 10)	$85,434,255	$ 82,827,389
Disproportionate share funding (notes 3 and 10)	4,325,004	4,100,348
Net patient service revenue, before provision for bad debts	89,759,259	86,927,737
Provision for bad debts (note 10)	(4,959,196)	(4,966,097)
Net patient service revenue, less provision for bad debts	84,800,063	81,961,640
Other revenue	5,634,597	6,024,480
Net assets released from restrictions for operations (note 9)	351,019	349,362
Total unrestricted revenue and other support	90,785,679	88,335,482
Expenses (note 14):		
Salaries and benefits (note 11)	46,412,326	44,398,572
Supplies and other (note 12)	35,079,595	34,011,294
Insurance (note 12)	513,476	515,518
Depreciation and amortization (note 7)	4,469,830	4,388,428
Interest (note 8)	1,030,574	1,078,378
New Hampshire Medicaid enhancement tax (note 3)	4,035,270	3,613,664
Total expenses	91,541,071	88,005,854
(Loss) income from operations	(755,392)	329,628
Nonoperating gains (losses):		
Investment income, net	1,351,735	6,797,853
Contributions without donor restrictions, net of fundraising expenses	(61,085)	68,228
Other expense	(1,109,599)	(285,346)
Nonoperating gains, net	181,051	6,580,735
(Deficiency) excess of revenue, support and nonoperating gains over expenses	(574,341)	6,910,363
Net unrealized gains (losses) on investments (note 6)	4,189,684	(103,293)
(Decrease) increase in fair value of interest rate swap agreements, qualifying as hedges (notes 8 and 16)	(1,851,185)	816,425
Net assets released from restrictions used to purchase property and equipment	277,958	415,851
Increase in net assets without donor restrictions	$ 2,042,116	$ 8,039,346

See accompanying notes.

THE MONADNOCK COMMUNITY HOSPITAL

STATEMENTS OF CHANGES IN NET ASSETS

Years Ended September 30, 2019 and 2018

	2019	2018
Net assets without donor restrictions:		
(Deficiency) excess of revenue, support and nonoperating gains over expenses	$ (574,341)	$ 6,910,363
Net unrealized gains (losses) on investments (note 6)	4,189,684	(103,293)
(Decrease) increase in fair value of interest rate swap agreements, qualifying as hedges (notes 8 and 16)	(1,851,185)	816,425
Net assets released from restrictions used to purchase property and equipment	277,958	415,851
Increase in net assets without donor restrictions	2,042,116	8,039,346
Net assets with donor restrictions:		
Donor-restricted contributions	169,256	493,404
Investment income, net	708,419	1,091,645
Change in perpetual trusts (note 6)	42,139	320,168
Net assets released from restrictions for operations (note 9)	(351,019)	(349,362)
Net assets released from restrictions used to purchase property and equipment	(277,958)	(415,851)
Increase in net assets with donor restrictions	290,837	1,140,004
Increase in net assets	2,332,953	9,179,350
Net assets, beginning of year	77,913,508	68,734,158
Net assets, end of year	$80,246,461	$77,913,508

See accompanying notes.

THE MONADNOCK COMMUNITY HOSPITAL

STATEMENTS OF CASH FLOWS

Years Ended September 30, 2019 and 2018

	2019	2018
Cash flows from operating activities:		
Increase in net assets	$ 2,332,953	$ 9,179,350
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	4,469,830	4,388,428
Bond issuance costs amortization	25,177	22,546
Realized and unrealized gains on investments and perpetual trusts, net	(5,032,565)	(7,162,444)
Change in fair value of interest rate swap agreements	1,851,185	(816,425)
Decrease in interest rate swap loan	(48,000)	(48,000)
Provision for bad debts	4,959,196	4,966,097
Restricted contributions and investment income	(877,675)	(559,420)
Changes in operating assets and liabilities:		
Accounts receivable	(4,393,658)	(5,672,611)
Inventories	83,857	4,052
Prepaid expenses	85,568	(149,965)
Notes and other receivables	(100,027)	132,289
Other assets	(4,415)	(4,459)
Accounts payable and accrued expenses	786,217	121,395
Accrued payroll and amounts withheld	36,333	101,277
Estimated third-party payor settlements	1,723,326	63,320
Net cash provided by operating activities	5,897,302	4,565,430
Cash flows from investing activities:		
Purchases of property and equipment	(3,920,932)	(4,724,538)
Proceeds on sale of investments	333,401	30,652,397
Purchases of investments	(1,513,196)	(36,546,185)
Net cash used by investing activities	(5,100,727)	(10,618,326)
Cash flows from financing activities:		
Principal payments on long-term debt and capital lease obligations	(713,218)	(689,297)
Bond issuance costs	104,218	(118,989)
Restricted contributions and investment income	983,025	700,219
Net cash provided (used) by financing activities	374,025	(108,067)
Net increase (decrease) in cash and cash equivalents	1,170,600	(6,160,963)
Cash and cash equivalents at beginning of year	12,271,683	18,432,646
Cash and cash equivalents at end of year	$ 13,442,283	$ 12,271,683
Noncash financing activities:		
Financing of equipment with capital leases	$ 537,973	$ –
Supplemental disclosure of cash flow information:		
Cash paid during the year for interest	$ 1,005,397	$ 1,055,832

See accompanying notes.

1. Description of Organization and Summary of Significant Accounting Policies

Organization

The Monadnock Community Hospital (the Hospital) is a not-for-profit, acute care hospital located in Peterborough, New Hampshire.

On December 30, 2016, the Hospital became affiliated with Catholic Medical Center (CMC), a 330-bed acute care hospital in Manchester, New Hampshire, and Huggins Hospital (HH), a 25-bed critical access hospital in Wolfeboro, New Hampshire, through the formation of a common parent, GraniteOne Health (GraniteOne). GraniteOne is a New Hampshire voluntary corporation that is recognized as being a Section 501(c)(3) tax-exempt and "supporting organization" within the meaning of Section 509(a)(3) of the Internal Revenue Code of 1986, as amended (the Code). GraniteOne serves as the sole member of the Hospital and HH and co-member of CMC, along with CMC Healthcare System, Inc. GraniteOne is governed by a thirteen member Board of Trustees appointed by each of the respective hospitals within the GraniteOne system. The GraniteOne Board of Trustees governs the GraniteOne system through the existence and execution of reserved powers to approve certain actions by the Boards of Trustees of each of the hospitals. Through GraniteOne, this more integrated healthcare system enhances the affiliated hospitals' ability to coordinate the delivery of patient care, implement best practices, eliminate inefficiencies and collaborate on regional planning. These efforts strengthen the hospitals' ability to meet the healthcare needs of their respective communities and provide for a more seamless patient experience across the continuum of care. The accompanying financial statements do not include the accounts and activity of GraniteOne, HH and CMC.

On September 30, 2019, GraniteOne, CMC, CMC Healthcare System (CMCHS), certain subsidiaries of CMCHS, HH and the Hospital entered into a combination agreement (the Agreement) with Dartmouth-Hitchcock Health (D-HH) to combine GraniteOne and D-HH and its members into a more fully integrated healthcare delivery system. Pursuant to the terms of the Agreement, the parties intend to revise D-HH's corporate name to Dartmouth-Hitchcock Health GraniteOne (D-HH GO), which will continue to serve as the sole corporate member of the existing D-HH System Members (Mary Hitchcock Memorial Health and Dartmouth-Hitchcock Clinic, New London Hospital (NHL), Cheshire Medical Center (Cheshire), Mt. Ascutney Hospital and Health Center (MAHHC), Alice Peck Day Memorial Hospital (APD) and Visiting Nurse and Hospice for Vermont and New Hampshire (VNH)), and which will be substituted for GraniteOne as the sole corporate member of HH and the Hospital and as co-member, of CMC and certain subsidiaries of CMCHS (the Combination). The overarching goal of the Combination is to create a New Hampshire-based, integrated and regionally distributed health care delivery system that better serves its patients and communities. While CMCHS will not be a component of the D-HH GO System, it will continue to serve as the corporate vehicle through which the Bishop of the Diocese of Manchester (the Bishop) ensures CMC's adherence to the Ethical and Religious Directives for Catholic Health Care Services. Neither CMCHS nor the Bishop will have authority over any other D-HH GO System member, including HH and the Hospital. Subject to certain rights reserved to the Bishop and CMCHS with respect to CMC and the CMCHS subsidiaries, D-HH GO will reserve to itself certain approval and initiation powers over the governance, financial, programmatic, administrative, and strategic decisions of D-HH GO System members.

1. **Description of Organization and Summary of Significant Accounting Policies (Continued)**

On December 30, 2019, GraniteOne, CMC, HH and the Hospital submitted a Joint Notice of Change of Control to the New Hampshire Attorney General, Director of Charitable Trusts pursuant to New Hampshire RSA 7:19-b beginning the regulatory review and approval process of the Combination. If all necessary approvals are obtained and closing conditions satisfied, D-HH GO will consist of a major academic medical center offering tertiary and quaternary services, an acute care community hospital in an urban setting (CMC), an acute care community hospital in a rural setting (Cheshire), five rural critical access hospitals (NLH, MAHHC, APD, HH and the Hospital), a post-acute home health and hospice provider (VNH), and nearly 1,800 employed and affiliated primary and specialty care physicians. D-HH GO System members will combine their resources to offer a broader array of inpatient, outpatient and ambulatory services.

Basis of Accounting

The accompanying financial statements have been prepared on an accrual basis of accounting.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents

Cash and cash equivalents include all demand deposit accounts and investments with original maturities of three months or less when purchased, excluding assets limited as to use. The Hospital maintains its cash in bank deposit accounts which, at times, may exceed federally insured limits. The Hospital has not experienced any losses on such accounts.

Accounts Receivable and the Allowance for Doubtful Accounts

Accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectibility of accounts receivable, the Hospital analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for bad debts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts. For receivables associated with services provided to patients who have third-party coverage, the Hospital analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts, if necessary (for example, for expected uncollectible deductibles and copayments on accounts for which the third-party payor has not yet paid, or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely). For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the Hospital records a provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

1. **Description of Organization and Summary of Significant Accounting Policies (Continued)**

Inventories

Inventories of supplies and pharmaceuticals are carried at the lower of cost or net realizable value. Costs are determined on the first-in, first-out (FIFO) basis.

Assets Limited as to Use

Assets limited as to use include assets held by trustees under indenture agreements, designated assets set aside by the Board of Trustees, over which the Board retains control and may, at its discretion, subsequently use for other purposes, and donor-restricted investments.

Investments

Investments are carried at fair value in the accompanying balance sheets. Investment income (including realized gains and losses on investments, interest and dividends) is included in the (deficiency) excess of revenue, support and nonoperating gains over expenses unless the income is restricted by donor or law, in which case it is reported as an increase or decrease in net assets with donor restrictions. Gains and losses on investments are computed on a specific identification basis, however, mutual fund realized gains and losses are determined on the average cost method. Unrealized gains and losses on investments are excluded from the (deficiency) excess of revenue, support and nonoperating gains over expenses unless losses are considered other-than-temporary. Periodically, management reviews investments for which the market value has fallen significantly below cost and recognizes impairment losses where they believe the declines are other-than-temporary.

Property and Equipment

Property and equipment, including the medical office building, is stated at cost or, if donated, at fair value at the date of donation, less accumulated depreciation. The Hospital's policy is to capitalize expenditures for major improvements and charge maintenance and repairs currently for expenditures which do not extend the life of the related assets. When assets are retired or disposed of, the assets and related accumulated depreciation are eliminated from the accounts and any resulting gain or loss is reflected in the accompanying statements of operations.

Depreciation is computed using the straight-line method in a manner intended to amortize the cost of the assets over their estimated useful lives. Costs of construction and acquisition of assets not yet placed in service are included in capital improvements and no depreciation expense is recorded.

Bond Issuance Costs

Bond issuance costs are being amortized to interest expense using straight-line method, which approximates the effective interest method, over the life of the respective bonds. Bond issuance costs are presented as a component of long-term debt.

1. **Description of Organization and Summary of Significant Accounting Policies (Continued)**

Earned Time

The Hospital provides and accrues for paid time off for vacation, holiday and sick leave under an earned time system for nonexempt employees. Hours earned, but not used, are capped and vested with the employee.

Net Assets With Donor Restrictions

Gifts are reported as restricted support if they are received with donor stipulations that limit the use of donated assets. Donated investments, supplies and equipment are reported at fair value at the date of receipt. Unconditional promises to give cash and other assets are reported at fair value at the date of the receipt of the promise. When a donor restriction expires (when a stipulated time restriction ends or purpose restriction is accomplished), net assets with donor restrictions are reclassified as net assets without donor restrictions and reported in the statement of operations as either net assets released from restrictions (for noncapital related items) or as net assets released from restrictions to purchase property and equipment (capital related items). Some net assets with donor restrictions have been restricted by donors to be maintained by the Hospital in perpetuity.

Except for contributions related to capital purchases, donor-restricted contributions whose restrictions are met within the same year as received are reported as contributions within net assets without donor restrictions in the accompanying financial statements.

Endowment, Investment and Spending Policies

In accordance with the *Uniform Prudent Management of Institutional Funds Act* (UPMIFA), the Hospital considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: (a) the duration and preservation of the fund; (b) the purpose of the organization and the donor-restricted endowment fund; (c) general economic conditions; (d) the possible effect of inflation and deflation; (e) the expected total return from income and the appreciation of investments; (f) other resources of the organization; and (g) the investment policies of the organization.

The Hospital's investment policies provide guidance for the prudent and skillful management of invested assets with the objective of preserving capital and maximizing returns. The invested assets include endowment, specific purpose and board designated (unrestricted) funds.

Endowment funds are identified as perpetual in nature, intended to provide support for current or future operations and other purposes identified by the donor. These funds are managed with disciplined longer-term investment objectives and strategies designed to accommodate relevant, reasonable, or probable events. The Finance Committee of the Board of Trustees of the Hospital determines the method to be used to appropriate endowment funds for expenditure. As a guideline, approximately 4% of the total value of the three year quarterly average of available funds is intended to be distributed annually. The Finance Committee has the ability to distribute up to 5.99% of the total market value of the three-year quarterly average of available funds. Distributions of 6% or over must be approved by a vote of the Board of Trustees. The corresponding calculated spending allocations are distributed in equal quarterly installments from the current net total or accumulated net total investment returns for individual endowment funds. In establishing this policy, the Board of Trustees considered the expected long term rate of return on its endowment.

1. **Description of Organization and Summary of Significant Accounting Policies (Continued)**

Specific purpose funds are temporary in nature, restricted as to time or purpose as identified by the donor or grantor. These funds have various intermediate/long-term time horizons associated with specific identified spending objectives.

Board designated funds have various intermediate/long-term time horizons associated with specific spending objectives as determined by the Board of Trustees.

Management of these assets is to increase, with minimum risk, the inflation adjusted principal and income of the endowment funds over the long term. The Hospital targets a diversified asset allocation that places emphasis on achieving its long-term return objectives within prudent risk constraints.

(Deficiency) Excess of Revenue, Support and Nonoperating Gains Over Expenses

The accompanying statements of operations include (deficiency) excess of revenue, support and nonoperating gains over expenses. Changes in net assets without donor restrictions which are excluded from (deficiency) excess of revenue, support and nonoperating gains over expenses, consistent with industry practice, include net assets released from restrictions used for the purposes of acquiring long-lived assets, net unrealized gains/losses on investments and the changes in the fair value of interest rate swap agreements deemed to be effective hedges.

Net Patient Service Revenue

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. Changes in these estimates are reflected in the accompanying financial statements in the year in which they occur. During 2019 and 2018, net patient service revenue in the accompanying statements of operations increased approximately $1,088,000 and $641,000, respectively, due to changes in prior year estimates. Services rendered to individuals from whom payment is expected and ultimately not received is written off and included as part of the provision for bad debts.

The Hospital recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered. For uninsured patients, the Hospital provides a discount approximately equal to that of its largest private insurance payors. On the basis of historical experience, a significant portion of the Hospital's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the Hospital records a significant provision for bad debts related to uninsured patients in the period the services are provided.

Activities directly associated with services related to acute and ancillary care services are considered to be operating activities and are included as patient service revenue. Revenue which is not related to patient medical care and which is normal to the day-to-day operations of the Hospital is included in other revenue.

1. **Description of Organization and Summary of Significant Accounting Policies (Continued)**

Financial Assistance Program

The Hospital accepts all patients regardless of their ability to pay. A patient is classified as a financial assistance patient by reference to certain established policies of the Hospital. Essentially, these policies define the financial assistance program as those services for which no payment is anticipated. In assessing a patient's inability to pay, the Hospital utilizes federally established poverty guidelines. The financial assistance program is measured based on the Hospital's established rates. These charges are not included in net patient service revenue. The costs and expenses incurred in providing these services are included in operating expenses. The cost is estimated by utilizing a ratio of cost to gross charges applied to the gross uncompensated charges associated with providing charity care. See note 15.

Self-Insurance Programs

The Hospital self-insures its employee health and dental benefits and has estimated and accrued amounts to meet its expected obligations under the program. The plan is administered by an insurance company which assists in determining the current funding requirements of participants under the terms of the plan and the liability for claims and assessments that would be payable at any given point in time. The Hospital recognizes revenue for services provided to employees of the Hospital during the year. Stop loss insurance coverage is in effect which mitigates the Hospital's exposure to loss on an individual and aggregate basis. Estimated unpaid claims, and those claims incurred but not reported at September 30, 2019 and 2018, have been recorded as a liability of approximately $410,000 and $300,000, respectively, within accrued payroll and amounts withheld in the accompanying balance sheets.

Functional Expense Allocation

The costs of providing program services and other activities have been summarized on a functional basis in Note 14. Accordingly, costs have been allocated among program services and supporting services benefitted.

Income Taxes

The Hospital is a not-for-profit corporation as described in Section 501(c)(3) of the Internal Revenue Code (the Code) and is exempt from federal income taxes on related income pursuant to Section 501(a) of the Code. Management evaluated the Hospital's tax positions and concluded the Hospital has maintained its tax-exempt status, does not have any significant unrelated business income and had taken no uncertain tax positions that require adjustment to or disclosure in the accompanying financial statements.

Advertising Costs

The Hospital expenses advertising costs as incurred, and such costs totaled approximately $53,000 and $83,000 for the years ended September 30, 2019 and 2018, respectively.

1. Description of Organization and Summary of Significant Accounting Policies (Continued)

Derivatives and Hedging Activities

The interest rate swap agreements held by the Hospital meet the definition of derivative instruments and, consequently, the Hospital is required to record as an asset or liability the fair value of the interest rate swap agreements described in Note 8. The Hospital is exposed to repayment loss equal to any net amounts receivable under the swap agreements (not the notional amounts) in the event of nonperformance of the other parties to the swap agreements. However, the Hospital does not anticipate nonperformance and does not obtain collateral from the other parties.

Related Party Activity

The Hospital has engaged in various transactions with GraniteOne and CMC. The Hospital recognized revenue from these related parties of approximately $378,000 and $340,000 for the years ended September 30, 2019 and 2018, respectively, which amounts are reflected in other revenue in the accompanying statements of operations. The Hospital also incurred expenses to these related parties of approximately $3.5 million and $3.1 million for the years ended September 30, 2019 and 2018, respectively, of which $2.9 million and $3.1 million, respectively, is reflected within operating expenses. Additionally, approximately $600,000 in related party expenses is reflected within nonoperating gains (losses) in the accompanying statement of operations for the year ended September 30, 2019. These transactions resulted in a net amount due to related parties of approximately $885,000 and $187,000 at September 30, 2019 and 2018, respectively, which amounts are reflected within accounts payable and accrued expenses in the accompanying balance sheets.

Recent Accounting Pronouncements

In August 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2016-14, *Not-for-Profit Entities (Topic 958)* (ASU 2016-14) – *Presentation of Financial Statements of Not-for-Profit Entities*. The update addresses the complexity and understandability of net asset classification, deficiencies in information about liquidity and availability of resources, and the lack of consistency in the type of information provided about expenses and investment return. ASU 2016-14 is effective for the Hospital for the year ended September 30, 2019. The Hospital has adjusted the presentation of these financial statements and related footnotes accordingly. The ASU has been applied retrospectively to all periods presented. The adoption of ASU 2016-14 had no impact to changes in net assets or total net assets in 2019 or 2018.

In May 2014, the FASB issued ASU No. 2014-09, *Revenue from Contracts with Customers* (ASU 2014-09), which requires revenue to be recognized when promised goods or services are transferred to customers in amounts that reflect the consideration to which the Hospital expects to be entitled in exchange for those goods and services. ASU 2014-09 will replace most existing revenue recognition guidance in U.S. GAAP when it becomes effective. ASU 2014-09 is effective for the Hospital on October 1, 2019. ASU 2014-09 permits the use of either the retrospective or cumulative effect transition method. The Hospital is evaluating the impact that ASU 2014-09 will have on its revenue recognition policies, but does not expect the new pronouncement will have a material impact on its financial statements.

1. **Description of Organization and Summary of Significant Accounting Policies (Continued)**

In January 2016, the FASB issued ASU No. 2016-01, *Financial Instruments – Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities* (ASU 2016-01). The amendments in ASU 2016-01 address certain aspects of recognition, measurement, presentation and disclosure of financial instruments. ASU 2016-01 is effective for the Hospital for the year ended September 30, 2020, with early adoption permitted. The Hospital is currently evaluating the impact that ASU 2016-01 will have on its financial statements.

In February 2016, the FASB issued ASU No. 2016-02, *Leases (Topic 842)* (ASU 2016-02). Under ASU 2016-02, at the commencement of a long-term lease, lessees will recognize a liability equivalent to the discounted payments due under the lease agreement, as well as an offsetting right-of-use asset. ASU 2016-02 is effective for the Hospital on October 1, 2021, with early adoption permitted. Lessees (for capital and operating leases) must apply a modified retrospective transition approach for leases existing at, or entered into after, the beginning of the earliest comparative period presented in the financial statements. The modified retrospective approach would not require any transition accounting for leases that expired before the earliest comparative period presented. Lessees may not apply a full retrospective transition approach. The Hospital is currently evaluating the impact of the pending adoption of ASU 2016-02 on the Hospital's financial statements.

In November 2016, the FASB issued ASU No. 2016-18, *Statement of Cash Flows (Topic 230): Restricted Cash (a consensus of the FASB Emerging Issues Task Force)* (ASU 2016-18), which provides guidance on the presentation of restricted cash or restricted cash equivalents in the statement of cash flows. ASU 2016-18 will be effective for the Hospital's fiscal year ended September 30, 2020, and early adoption is permitted. ASU 2016-18 must be applied using a retrospective transition method. The Hospital is currently evaluating the impact of the adoption of this guidance on its financial statements.

In June 2018, the FASB issued ASU No. 2018-08, *Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made* (ASU 2018-08). Due to diversity in practice, ASU 2018-08 clarifies the definition of an exchange transaction as well as the criteria for evaluating whether contributions are unconditional or conditional. ASU 2018-08 is effective for the Hospital on October 1, 2019, with early adoption permitted. The Hospital is currently evaluating the impact that ASU 2018-08 will have on its financial statements.

In August 2018, the FASB issued ASU 2018-13, *Fair Value Measurement (Topic 820): Disclosure Framework – Changes to the Disclosure Requirements for Fair Value Measurement* (ASU 2018-13). The amendments in this ASU modify the disclosure requirements for fair value measurements for Level 3 assets and liabilities, and eliminate the requirement to disclose transfers between Levels 1 and 2 of the fair value hierarchy, among other modifications. ASU 2018-13 is effective for the Hospital on October 1, 2020, with early adoption permitted. The Hospital is currently evaluating the impact that ASU 2018-13 will have on its financial statements.

Subsequent Events

Management has evaluated subsequent events occurring between the end of its fiscal year and January 21, 2020, the date the financial statements were available to be issued.

2. Accounts Receivable

Accounts receivable are stated net of estimated contractual allowances and allowances for doubtful accounts. Accounts receivable consists of the following at September 30:

	2019	2018
Gross accounts receivable	$23,422,989	$24,239,257
Estimated contractual allowances	(7,681,727)	(8,305,416)
Estimated allowance for doubtful accounts	(6,833,581)	(6,460,622)
Accounts receivable, net	$ 8,907,681	$ 9,473,219

The Hospital's allowance for doubtful accounts decreased from 91% of self-pay accounts receivable at September 30, 2018 to 89% of self-pay accounts receivable at September 30, 2019. The Hospital's bad debt writeoffs decreased $174,645 from $4,713,049 in 2018 to $4,538,404 in 2019. The decrease in bad debt writeoffs was primarily a result of collection trends.

3. Estimated Third-Party Settlements

The Hospital has agreements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows:

Medicare

The Hospital was granted critical access hospital (CAH) designation on December 27, 2004. As a result of this designation, the Hospital is entitled to cost-based reimbursement from Medicare for services provided to Medicare beneficiaries. Inpatient acute care services rendered to Medicare program beneficiaries are paid under a cost reimbursement methodology. Outpatient services are paid based on a combination of rate schedules and reimbursed cost. The Hospital is reimbursed for cost reimbursable items at an interim rate with final settlement determined after submission of annual cost reports by the Hospital and audits thereof by the Medicare fiscal intermediary. As of the date of these financial statements, the Hospital's Medicare cost reports have been settled through September 30, 2015.

Medicaid

Inpatient and outpatient services rendered to Medicaid program beneficiaries are reimbursed under a cost reimbursement methodology subject to certain limitations. The Hospital is reimbursed at an interim rate with final settlement determined after submission of annual costs reported by the Hospital and audits thereof by the State of New Hampshire Division of Audit. As of the date of these financial statements, the Hospital's Medicaid cost reports have been final settled through September 30, 2013.

3. Estimated Third-Party Settlements (Continued)

Anthem

Inpatient and outpatient services rendered to Anthem subscribers are reimbursed at submitted charges less a discount withholding or through a per diem or fee schedule. The amounts paid to the Hospital are not subject to any retroactive adjustments.

Other

The Hospital has also entered into payment agreements with certain commercial insurance carriers and health maintenance organizations. The basis for payment to the Hospital under these agreements includes prospectively determined rates per discharge, per diems and discounts from established charges.

The Hospital has made a provision in the financial statements for estimated final settlements to be paid as a result of the retroactive provision for third-party reimbursement programs. Actual results could differ from those estimates.

Medicaid Enhancement Tax and Medicaid Disproportionate Share

Under the State of New Hampshire's tax code, the State imposes a MET equal to 5.4% of net patient service revenue in State fiscal years 2019 and 2018, with certain exclusions. The amount of tax incurred by the Hospital for fiscal 2019 and 2018 was $4,035,270 and $3,613,664, respectively. The Hospital has accrued $1,022,102 and $948,566 in MET at September 30, 2019 and 2018, respectively, within accounts payable and accrued expenses in the accompanying balance sheets.

In the fall of 2010, in order to remain in compliance with stated federal regulations, the State of New Hampshire adopted a new approach related to Medicaid disproportionate share funding (DSH) retroactive to July 1, 2010. Unlike the former funding method, the State's approach led to a payment that was not directly based on, and did not equate to, the level of tax imposed. As a result, the legislation created some level of losses at certain New Hampshire hospitals, while other hospitals realized gains. In 2019 and 2018, the Hospital recognized disproportionate share revenues (net of related reserves) totaling $4,325,004 and $4,100,348, respectively, in the accompanying statements of operations. Currently, the State of New Hampshire makes disproportionate share hospital payments to support up to 75% of the actual uncompensated care costs for New Hampshire's hospitals with critical access designation.

CMS has completed audits of the State's program and the DSH payments made by the State from 2011 through 2014, the first years that those payments reflected the amount of uncompensated care provided by New Hampshire hospitals. It is possible that subsequent years will also be audited by CMS. The Hospital has recorded reserves to address its potential exposure based on the audit results to date or any future redistributions.

4. Concentration of Credit Risk

Financial instruments which subject the Hospital to credit risk consist of cash and cash equivalents, accounts receivable and investments. The risk with respect to cash equivalents is minimized by the Hospital's policy of investing in financial instruments with short-term maturities issued by highly rated financial institutions. Investments that exceeded 10% of investments include the Vanguard Total Stock Market Index Fund and the Vanguard Total International Stock Index Fund as of September 30, 2019 and 2018.

The Hospital grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The Hospital's accounts receivable are primarily due from third-party payors, and amounts are presented net of expected contractual allowances and uncollectible amounts. The mix of gross patient accounts receivable at September 30, 2019 and 2018 was as follows:

	2019	2018
Medicare	31%	33%
Medicaid	5	4
Anthem	9	10
Other third-party payors	25	28
Patients	30	25
	100%	100%

5. Pledges Receivable

Pledges receivable consist of unconditional promises for contributions receivable in subsequent years. The following represents amounts promised to be contributed to the Hospital during the years ended September 30:

	2019	2018
In one year or less	$ 202,053	$ 207,967
Between one and five years	225,000	325,121
	427,053	533,088
Present value discount	(27,346)	(39,759)
Allowance for uncollectible pledges ($106,815 and $112,044 of which is allocated to the current portion of pledges receivable at September 30, 2019 and 2018, respectively)	(209,399)	(197,671)
	$ 190,308	$ 295,658

6. Assets Limited as to Use and Restricted Funds

The composition of assets limited as to use at September 30, 2019 and 2018 is set forth in the following table. Investments are stated at fair value.

	2019	2018
Board designated, donor restricted and long-term investments:		
Cash and cash equivalents	$ 1,216,991	$ 1,038,519
Marketable equity securities	33,844,646	29,504,809
Mutual funds	32,815,296	31,116,523
U.S. Treasury obligations	996,372	1,043,233
Interests in perpetual trusts	4,862,084	4,819,945
	$73,735,389	$67,523,029

Assets limited as to use are comprised of the following at September 30:

	2019	2018
Board designated for capital, working capital and community services	$60,217,816	$54,401,643
Donor-restricted	13,517,573	13,121,386
	$73,735,389	$67,523,029

As a result of bequests, the Hospital is the beneficiary of two trust funds, one of which is administered by an outside trustee and the other administered by the Hospital. The terms of the perpetual trusts require that income or a percentage of income be paid to the Hospital in perpetuity; however, distribution of principal is not permitted under the terms of the trusts. The amounts recorded in the accompanying balance sheets represent the fair values of the assets upon notification of the trusts' existence, which are adjusted annually to reflect the appreciation or depreciation in the fair value of the assets. Offsetting amounts are included in net assets with donor restrictions. Income distributed to the Hospital from these trusts is included in the accompanying statements of operations as investment income.

The following table summarizes the aggregate unrealized losses on investments held at September 30, 2019 and 2018:

	Less Than 12 Months		12 Months or Longer		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
2019						
Marketable equity securities	$ –	$ –	$ 547,715	$ (1,258)	$ 547,715	$ (1,258)
Mutual funds	28,051	(3,976)	6,316,341	(862,137)	6,344,392	(866,113)
Fixed income	–	–	199,531	(1,250)	199,531	(1,250)
	$ 28,051	$ (3,976)	$7,063,587	$(864,645)	$ 7,091,638	$(868,621)

6. Assets Limited as to Use and Restricted Funds (Continued)

	Less Than 12 Months		12 Months or Longer		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
2018						
Marketable equity securities	$ 1,047,737	$ (90,250)	$ –	$ –	$ 1,047,737	$ (90,250)
Mutual funds	16,150,652	(870,927)	–	–	16,150,652	(870,927)
Fixed income	391,215	(4,636)	552,832	(20,239)	944,047	(24,875)
	$17,589,604	$(965,813)	$ 552,832	$ (20,239)	$18,142,436	$(986,052)

Unrealized losses within marketable equity securities of $1,258 at September 30, 2019, due mainly to market fluctuations, consists of one security, which had unrealized losses for more than twelve months. Unrealized losses within mutual funds of $866,113 at September 30, 2019, due mainly to market fluctuations, consist of four funds, three of which had unrealized losses for more than twelve months. Other unrealized losses in the Hospital's fixed income portfolio of $1,250 at September 30, 2019 consist of two funds, both of which had unrealized losses for more than twelve months, and are attributed to market fluctuations and the impact movements in market interest rates have had in comparison to the underlying yields on these securities.

Management of the Hospital, in addition to considering current trends and economic conditions that may affect the quality of individual securities within the Hospital's investment portfolio, also considers the Hospital's ability and intent to hold such securities to maturity or recovery. Management does not believe any of the Hospital's securities with unrealized losses as described above are other than temporarily impaired at September 30, 2019 and 2018.

7. Property and Equipment

Property and equipment consists of the following at September 30:

	2019	2018
Land and land improvements	$ 4,686,848	$ 4,686,848
Building and building improvements	29,157,921	28,242,378
Equipment, including capital leases	61,208,473	59,374,059
Capital improvements in progress	1,394,124	1,114,597
	96,447,366	93,417,882
Less accumulated depreciation and amortization	(60,457,341)	(57,511,929)
	$ 35,990,025	$ 35,905,953

The cost of assets recorded under capital leases totaled $537,973 and $679,756 at September 30, 2019 and 2018, respectively. The cost of these assets has been included with property and equipment, and accumulated amortization included with accumulated depreciation. Accumulated amortization associated with assets recorded under capital leases was $84,992 and $600,451 at September 30, 2019 and 2018, respectively.

8. Long-Term Debt and Capital Lease Obligations

Long-term debt consists of the following at September 30:

	2019	2018
New Hampshire Business Finance Authority (NHBFA) in conjunction with Revenue Bonds Series 2013 with variable rate interest, amended and restated as of June 27, 2018, as described below	$23,827,318	$24,399,669
Interest rate swap loan (see below)	44,000	92,000
Capital lease obligation with interest rate of 3.25%, due in monthly installments of $12,290, matured in May 2019, collateralized by equipment (note 7)	–	97,132
Capital lease obligations with interest rates of 5.25%, due in monthly installments ranging from $5,680 to $7,495, maturity dates ranging from April 2022 to October 2023, collateralized by equipment (note 7)	494,238	–
	24,365,556	24,588,801
Less unamortized bond issuance costs	(37,233)	(166,628)
Less current portion	(777,725)	(717,483)
	$23,550,598	$23,704,690

On January 1, 2013, the Hospital refinanced its existing 2007 Series Bonds outstanding in the amount of $17,810,000 and its 2009 Series Bonds outstanding in the amount of $9,424,908 through the issuance of $27,240,000 in 2013 Series Bonds with NHBFA. The initial interest rate on the bonds through January 1, 2023 was a variable rate equal to 75% of the one-month LIBOR plus 1.3125%. The final maturity of the bonds was January 1, 2043 and on January 1, 2023, the bonds were required to be remarketed upon a stipulated mandatory redemption.

On June 27, 2018, the 2013 Series Revenue Bonds with NHBFA were amended and restated. The original bonds were exchanged for amended bonds and the original bond issuance was cancelled. The amended 2013 Series Bonds with NHBFA were issued in the amount of $24,584,872, which was the amount of the outstanding balance of the original 2013 Series Bonds at the time of closing. The initial interest rate on the amended bonds through July 1, 2028 is a variable rate equal to 81.5% of the one-month LIBOR plus 1.45%. The interest rate at September 30, 2019 was 2.89%. The final maturity of the amended bonds remained January 1, 2043. On January 1, 2028, the amended bonds must be remarketed upon a stipulated mandatory redemption. The Hospital is also required to comply with certain financial and other covenants and has granted as security all gross receipts, together with all real and personal property, as defined. The amended Series 2013 Bonds require the same debt service payments as the original 2013 Series Bonds with payments ranging from $408,605 to $1,589,792 per year.

8. Long-Term Debt and Capital Lease Obligations (Continued)

Concurrent with the 2007 NHBFA bond issuance, the Hospital executed an interest rate swap agreement to hedge its exposure to the volatility of interest payments on a portion of its variable rate Series 2007 Revenue Bonds. During 2013, the Series 2007 Revenue Bonds were refinanced through the issuance of Series 2013 Revenue Bonds, as previously discussed. All existing terms of the swap remained in effect. At September 30, 2019, an interest rate swap agreement was outstanding at a notional amount totaling approximately $8.5 million. The swap agreement hedged the Hospital's interest exposure by effectively converting interest payments from variable rates to a fixed rate of 3.57%. The swap agreement, which expires in October 2033, is designated as a cash flow hedge of the underlying variable rate interest payments, and changes in the fair value of the swap agreement are reported as a change in net assets without donor restrictions. The swap agreement had a fair value of $(1,590,552) and $(1,005,561) as of September 30, 2019 and 2018, respectively.

The Hospital had another interest rate swap agreement with a financial institution, which was originally issued in connection with the 2004 New Hampshire Health and Education Facilities Authority (NHHEFA) bonds, which were refunded during 2008. During 2010, the Hospital replaced this 2004 swap agreement with a new 2010 swap agreement that effectively hedged a portion of the 2007 NHBFA bonds. This newly issued swap agreement contained an additional interest rate spread, which in turn provided that the issuing bank make a cash payment to fund the payoff of the 2004 swap agreement on behalf of the Hospital. Accordingly, the Hospital recognized an interest rate swap loan liability of $480,000 during 2010, which represents the fair value of the 2004 swap at the time it was replaced. This loan was being amortized by the Hospital over the life of the new swap agreement. As a part of the 2013 Series Bonds amendment previously discussed, this swap agreement was terminated during 2018.

Concurrent with the amended and restated 2013 Series Revenue Bonds, the Hospital executed an interest rate swap agreement effective July 1, 2018 to hedge its exposure to the volatility of interest payments on a portion of its variable rate on the amended and restated 2013 Series Revenue Bonds. At September 30, 2019, an interest rate swap agreement was outstanding at a notional amount totaling approximately $13.8 million. The swap agreement hedges the Hospital's interest exposure by effectively converting interest payments from variable rates to a fixed rate of 2.64%. The swap agreement, which expires July 1, 2028, is designated as a cash flow hedge of the underlying variable interest payments, and changes in the fair value of the swap agreement are reported as a change in net assets without donor restrictions. The swap agreement had a fair value of $(1,438,209) and $(172,015) as of September 30, 2019 and 2018, respectively.

During the year, the Hospital pays or receives the difference between the fixed and variable rates applied to the notional amounts of the above interest rate swap agreements. During 2019 and 2018, such charges were $214,990 and $383,554, respectively.

In connection with the amended and restated 2013 Series Revenue Bonds, the Hospital is required to comply with certain restrictive financial covenants including, but not limited to, debt service coverage and debt to equity ratios. At September 30, 2019, the Hospital was in compliance with these restrictive covenants.

8. Long-Term Debt and Capital Lease Obligations (Continued)

The scheduled maturities on long-term debt for the next five years ending September 30 and thereafter are as follows:

	Long-Term Debt	Capital Lease Obligations	Total
2020 (included in current liabilities)	$ 642,346	$135,379	$ 777,725
2021	625,522	142,660	768,182
2022	653,933	121,683	775,616
2023	683,634	87,053	770,687
2024	714,684	7,463	722,147
Thereafter	20,551,199	–	20,551,199
	$23,871,318	$494,238	$ 24,365,556

The Hospital also has an available $3,000,000 revolving demand line of credit with a financial institution. The line of credit bears no interest unless drawn at the Hospital's option in which case the rate is equal to the prime rate or 1, 2 or 3 month LIBOR plus 2.5% (5.00% at September 30, 2019). There was no balance outstanding under this agreement at September 30, 2019 or 2018. The line of credit is subject to renewal on May 31, 2020.

9. Net Assets With Donor Restrictions

Net assets with donor restrictions are available for the following purposes at September 30:

	2019	2018
Subject to expenditure for specific purposes:		
Purchase of equipment	$ 6,522	$ 6,522
Health education	572,553	550,489
Pledges receivable	190,308	295,658
	769,383	852,669
Restricted endowments:		
General endowment to ensure the Hospital's long-term sustainability, its services and its many community outreach programs	8,076,414	7,744,430
Perpetual trusts (described below)	4,862,084	4,819,945
	$13,707,881	$13,417,044

Net assets with donor restrictions of $4,862,084 and $4,819,945 at September 30, 2019 and 2018, respectively, are to be held in perpetuity and include two perpetual trusts (Note 6). The income and dividends on net assets held in perpetuity are generally expendable to support health care services and capital purchases at the discretion of the Hospital.

9. Net Assets With Donor Restrictions (Continued)

All of the Hospital's endowment funds are donor-restricted. The Hospital does not have any board-designated or endowments without donor restrictions at September 30, 2019 and 2018. The endowment net assets as of September 30, 2019 and 2018 are as follows:

	With Donor Restrictions	
	2019	2018
Original donor-restricted gift amount and amounts required to be maintained in perpetuity by donor	$4,220,482	$ 4,220,482
Accumulated investment gains	3,855,932	3,523,948
	$8,076,414	$ 7,744,430

Activity in fiscal 2019 and 2018 related to endowment funds was as follows:

	2019	2018
Balances, beginning of year	$7,744,430	$ 6,959,490
Investment return, net	735,202	1,148,758
Amounts released under spending policy	(268,104)	(239,649)
Appropriation for expenditure	(135,114)	(124,169)
Balances, end of year	$8,076,414	$ 7,744,430

From time to time, certain donor-restricted endowment funds may have fair values less than the amount required to be maintained by donors or by law (underwater endowments). The Hospital has interpreted UPMIFA to permit spending from underwater endowments in accordance with prudent measures required under law. At September 30, 2019 and 2018, the Hospital had no underwater endowments.

10. Net Patient Service Revenue

Net patient service revenue, before provision for bad debts, consists of the following for the years ended September 30:

	2019	2018
Gross patient service charges:		
Routine services	$ 18,013,983	$ 18,920,316
Ancillary services	149,779,911	143,010,656
	167,793,894	161,930,972
Deductions from revenue:		
Contractual adjustments and administrative write offs	(80,527,322)	(77,370,032)
Financial assistance program	(1,832,317)	(1,733,551)
Disproportionate share funding (note 3)	4,325,004	4,100,348
	(78,034,635)	(75,003,235)
Net patient service revenue, before provision for bad debts	$ 89,759,259	$ 86,927,737

10. Net Patient Service Revenue (Continued)

An estimated breakdown of patient service revenue, net of contractual allowances, discounts and provision for bad debts recognized in 2019 and 2018 from these major payor sources, is as follows:

	Gross Patient Service Revenue	Contractual Allowances and Discounts	Provision for Bad Debts	Net Patient Service Revenue Less Provision for Bad Debts
2019				
Private payors (includes coinsurance and deductibles)	$ 65,984,775	$(28,577,716)	$ (3,798,064)	$33,608,995
Medicaid	13,786,476	(9,722,345)	(37,850)	4,026,281
Medicare	81,401,773	(36,381,066)	(121,077)	44,899,630
Self-pay	6,620,870	(3,353,508)	(1,002,205)	2,265,157
	$167,793,894	$(78,034,635)	$ (4,959,196)	$84,800,063
2018				
Private payors (includes coinsurance and deductibles)	$ 68,650,215	$(28,779,974)	$ (3,875,381)	$35,994,860
Medicaid	10,188,961	(6,923,199)	(44,230)	3,221,532
Medicare	77,148,328	(36,411,872)	(221,566)	40,514,890
Self-pay	5,943,468	(2,888,190)	(824,920)	2,230,358
	$161,930,972	$(75,003,235)	$ (4,966,097)	$81,961,640

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The Hospital believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation, as well as significant regulatory action including fines, penalties and exclusion from the Medicare and Medicaid programs.

11. Employee Benefit Plans

The Hospital has a tax-sheltered annuity plan covering substantially all of its employees. Participating employees become eligible for employer contributions following the completion of two years of service, as defined, and attainment of age 21. Employer contributions are determined based on a percentage of employees' salaries. Benefit expense related to this plan for the years ended September 30, 2019 and 2018 amounted to approximately $528,000 and $502,000, respectively.

The Hospital also offers to certain physicians the option to participate in an Internal Revenue Code Section 457 deferred compensation plan to which the Hospital may make a discretionary contribution. The Hospital made no contributions to the Plan for the years ended September 30, 2019 and 2018.

12. Commitments and Contingencies

Operating Leases

The Hospital has various operating leases relative to certain equipment and various office facilities. Future annual minimum lease payments under these noncancellable leases as of September 30, 2019 are as follows:

Year ending September 30:	
2020	$298,659
2021	218,969
2022	188,957
2023	80,229

Rent expense was approximately $373,000 and $559,000 for the years ended September 30, 2019 and 2018, respectively.

Malpractice Loss Contingencies

The Hospital maintains malpractice insurance coverage on a claims-made basis. The claims-made policies, which are subject to retrospective adjustment and renewal on an annual basis, cover only claims made during the term of the policies, but not those occurrences for which claims may be made after expiration of the policies. The Hospital intends to renew its coverage and has no reason to believe that it will be prevented from renewing such coverage.

In accordance with ASU No. 2010-24, *"Health Care Entities" (Topic 954): Presentation of Insurance Claims and Related Recoveries*, the Hospital is required to record a liability related to estimated professional liability losses and also a receivable related to estimated recoveries under insurance coverage for recoveries of potential losses. At September 30, 2019 and 2018, management of the Hospital estimated that the Hospital did not have any significant exposure arising from estimated professional liability losses or significant estimated recoveries under insurance coverage for recoveries of potential losses.

13. Volunteer Services (Unaudited)

In 2019 and 2018, total volunteer service hours received by the Hospital were approximately 13,300 and 11,900, respectively. The volunteers provide nonspecialized services to the Hospital, none of which have been recognized as revenue or expense in the statements of operations.

14. Functional Expenses

The Hospital provides general health care services to residents within its geographic location. Expenses, excluding the New Hampshire Medicaid enhancement tax, related to providing these services are as follows for the year ended September 30, 2019:

	Health Services	General and Administrative	Total
Salaries and benefits	$41,223,662	$ 5,188,664	$46,412,326
Supplies and other	31,488,254	3,591,341	35,079,595
Insurance	414,521	98,955	513,476
Depreciation and amortization	4,273,126	196,704	4,469,830
Interest	–	1,030,574	1,030,574
	$77,399,563	$10,106,238	$87,505,801

For the year ended September 30, 2018, the Hospital provided $75,127,027 in health services expenses and $9,265,163 in general and administrative expenses, excluding New Hampshire Medicaid enhancement tax.

The financial statements report certain expense categories that are attributable to more than one healthcare service or support function. Therefore, these expenses require an allocation on a reasonable basis that is consistently applied. Costs not directly attributable to a function, such as depreciation and interest, are allocated to a function based on square footage. Supporting activities that are not directly identifiable with one or more healthcare programs are classified as general and administrative. If it is impossible or impractical to make a direct identification, allocation of the expenses were made according to management's estimates. Employee benefits are allocated in accordance with the ratio of salaries and wages of the functional classes. Specifically identifiable costs are assigned to the function which they are identified to.

15. Financial Assistance Program and Community Benefits (Unaudited)

The Hospital maintains records to identify and monitor the level of financial assistance it provides. These records include the amount of charges foregone for services and supplies furnished under its financial assistance program, the estimated cost of those services and supplies, and equivalent service statistics. The following information measures the level of financial assistance provided during the years ended September 30, 2019 and 2018:

	2019	2018
Charges foregone, based on established rates (note 1)	$1,832,000	$1,734,000
Estimated costs incurred to provide financial assistance	$1,058,000	$ 992,000
Equivalent percentage of financial assistance services to all services	1.09%	1.07%

15. Financial Assistance Program and Community Benefits (Unaudited) (Continued)

In addition to the financial assistance identified above, the Hospital does not receive full payment from the Medicare and Medicaid programs for the cost of services to certain poor and elderly patients served. In 2019 and 2018, the Hospital incurred costs in excess of payments in these programs amounting to approximately $5,794,000 and $4,420,000, respectively.

The Hospital also provides other services to the community at no cost or reduced cost, such as screenings, clinics, etc. The cost of providing these services was approximately $4,062,000 and $3,350,000 for the years ended September 30, 2019 and 2018, respectively.

The Hospital also has direct subsidies of approximately $4,448,000 and $4,355,000 for primary care and various specialty practices for the years ended September 30, 2019 and 2018, respectively.

16. Fair Value of Financial Instruments

Fair value of a financial instrument is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. In determining fair value, the Hospital uses various methods including market, income and cost approaches. Based on these approaches, the Hospital often utilizes certain assumptions that market participants would use in pricing the asset or liability, including assumptions about risk and or the risks inherent in the inputs to the valuation technique. These inputs can be readily observable, market corroborated, or generally unobservable inputs. The Hospital utilizes valuation techniques that maximize the use of observable inputs and minimize the use of unobservable inputs. Based on the observability of the inputs used in the valuation techniques, the Hospital is required to provide the following information according to the fair value hierarchy. The fair value hierarchy ranks the quality and reliability of the information used to determine fair values. Financial assets and liabilities carried at fair value will be classified and disclosed in one of the following three categories:

Level 1 – Valuations for assets and liabilities traded in active exchange markets, such as the New York Stock Exchange. Level 1 also includes U.S. Treasury and federal agency securities and federal agency mortgage-backed securities, which are traded by dealers or brokers in active markets. Valuations are obtained from readily available pricing sources for market transactions involving identical assets or liabilities.

Level 2 – Valuations for assets and liabilities traded in less active dealer or broker markets. Valuations are obtained from third party pricing services for identical or similar assets or liabilities.

Level 3 – Valuations for assets and liabilities that are derived from other valuation methodologies, including option pricing models, discounted cash flow models and similar techniques, and not based on market exchange, dealer or broker traded transactions. Level 3 valuations incorporate certain assumptions and projections in determining the fair value assigned to such assets or liabilities.

16. Fair Value of Financial Instruments (Continued)

In determining the appropriate levels, the Hospital performs a detailed analysis of the assets and liabilities that are subject to fair value measurements. At each reporting period, all assets and liabilities for which the fair value measurement is based on significant unobservable inputs are classified as Level 3.

For the fiscal year ended September 30, 2019, the application of valuation techniques applied to similar assets and liabilities has been consistent with prior years.

The following presents the balances of assets and liabilities measured at fair value on a recurring basis at September 30:

	Total	Level 1	Level 2	Level 3
2019				
Assets:				
Assets limited as to use:				
Cash and cash equivalents	$ 1,216,991	$ 577,893	$ 639,098	$ –
U.S. Treasury obligations	996,372	996,372	–	–
U.S. common stock:				
Technology	9,015,310	9,015,310	–	–
Healthcare	3,555,498	3,555,498	–	–
Consumer goods	8,649,955	8,649,955	–	–
Industrial goods	2,838,439	2,838,439	–	–
Services	7,778,038	7,778,038	–	–
Financial	1,017,198	1,017,198	–	–
Utilities	990,208	990,208	–	–
Mutual funds:				
Domestic	10,878,877	10,878,877	–	–
International	6,373,129	6,373,129	–	–
Fixed income	15,563,290	15,563,290	–	–
Investments in perpetual trusts	4,862,084	–	4,862,084	–
	$73,735,389	$68,234,207	$5,501,182	$ –
Liabilities:				
Interest rate swap agreements	$ 3,028,761	$ –	$ –	$3,028,761

16. Fair Value of Financial Instruments (Continued)

The following presents the balances of assets and liabilities measured at fair value on a recurring basis at September 30:

	Total	Level 1	Level 2	Level 3
2018				
Assets:				
Assets limited as to use:				
Cash and cash equivalents	$ 1,038,519	$ 548,393	$ 490,126	$ –
U.S. Treasury obligations	1,043,233	1,043,233	–	–
U.S. common stock:				
Technology	8,485,427	8,485,427	–	–
Healthcare	3,276,072	3,276,072	–	–
Consumer goods	6,847,685	6,847,685	–	–
Industrial goods	2,315,356	2,315,356	–	–
Services	7,228,649	7,228,649	–	–
Financial	639,320	639,320	–	–
Utilities	712,300	712,300	–	–
Mutual funds:				
Domestic	10,568,725	10,568,725	–	–
International	6,391,702	6,391,702	–	–
Fixed income	14,156,096	14,156,096	–	–
Investments in perpetual trusts	4,819,945	–	4,819,945	–
	$67,523,029	$62,212,958	$5,310,071	$ –
Liabilities:				
Interest rate swap agreements	$ 1,177,576	$ –	$ –	$1,177,576

The valuation of the interest rate swap agreements is estimated by a third party based on the anticipated cash flows under the swap agreements over their duration at market interest rates at September 30, 2019 and 2018.

The following presents the change in Level 3 instruments for the years ended September 30:

	Interest Rate Swaps	
	2019	2018
Balance, beginning of year	$ (1,177,576)	$ (1,994,001)
Total unrealized (losses) gains, included in changes in net assets without donor restrictions	(1,851,185)	816,425
Balance, end of year	$ (3,028,761)	$ (1,177,576)

16. Fair Value of Financial Instruments (Continued)

Investments, in general, are exposed to various risks, such as interest rate, credit and overall market volatility. As such, it is reasonably possible that changes in the fair value of investments will occur in the near term and that such changes could materially affect the amounts reported in the accompanying balance sheets and statements of operations.

The following methods and assumptions were used by the Hospital in estimating the "fair value" of other financial instruments in the accompanying financial statements and notes thereto:

Cash and cash equivalents: The carrying amounts reported in the accompanying statements of financial position for these financial instruments approximate their fair values.

Accounts and other receivables, pledges receivable, notes receivable, accounts payable and estimated third-party payor settlements: The carrying amounts reported in the accompanying statements of financial position approximate their respective values as these financial instruments have short-term maturities or are recorded at amounts that approximate fair value.

Long-term debt: The fair value of substantially all long-term debt approximates its carrying value due to the variable rate interest terms.

17. Financial Assets and Liquidity Resources

Financial assets and liquidity resources available within one year for general expenditure, such as operating expenses, scheduled principal payments on debt, and capital construction costs not financed with debt, consisted of the following at September 30, 2019:

Cash and cash equivalents	$13,442,283
Accounts receivable	8,907,681
Other receivables	641,032
	$22,990,996

To manage liquidity, the Hospital maintains sufficient cash and cash equivalent balances to support daily operations throughout the year. Cash and cash equivalents include bank deposits, money market funds, and other similar vehicles that generate a return on cash and provide daily liquidity to the Hospital. In addition, the Hospital has board-designated assets without donor restrictions that can be utilized at the discretion of management to help fund both operational needs and/or capital projects. As of September 30, 2019, the balance in board-designated assets was approximately $60 million.

Attachment 8

HH Audited Financial Statements FY 2019

HUGGINS HOSPITAL AND SUBSIDIARY

CONSOLIDATED FINANCIAL STATEMENTS

and

SUPPLEMENTARY INFORMATION

September 30, 2019 and 2018

With Independent Auditor's Report

HUGGINS HOSPITAL AND SUBSIDIARY

Index to Consolidated Financial Statements and Supplementary Information

September 30, 2019 and 2018

BerryDunn

INDEPENDENT AUDITOR'S REPORT

Board of Trustees
Huggins Hospital and Subsidiary

We have audited the accompanying consolidated financial statements of Huggins Hospital and Subsidiary, which comprise the consolidated balance sheets as of September 30, 2019 and 2018, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with U.S. generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

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

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Huggins Hospital and Subsidiary as of September 30, 2019 and 2018, and the results of their operations, changes in their net assets, and their cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.

Change in Accounting Principle

As discussed in Note 1 to the financial statements, in 2019 Huggins Hospital and Subsidiary adopted new accounting guidance, Financial Accounting Standards Board Accounting Standards Update No. 2016-14, Not-for-Profit Entities (Topic 958), *Presentation of Financial Statements of Not-for-Profit Entities*. Our opinion is not modified with respect to this matter.

Other Matter

Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. Schedules 1 and 2 are presented for purposes of additional analysis of the consolidated financial statements rather than to present the financial position and results of operations of the individual organizations, and are not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with U.S. generally accepted auditing standards. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Berry Dunn McNeil & Parker, LLC

Portland, Maine
February 3. 2020

HUGGINS HOSPITAL AND SUBSIDIARY

Consolidated Balance Sheets

September 30, 2019 and 2018

ASSETS

	2019	2018
Current assets		
Cash and cash equivalents	**$ 10,897,609**	$ 8,994,916
Accounts receivable from patients, less allowances for uncollectible accounts and contractuals (2019 - $8,660,000; 2018 - $8,228,000)	**8,802,983**	7,436,595
Other accounts and notes receivable	**1,500,892**	3,446,185
Other current assets	**1,547,798**	812,190
Total current assets	**22,749,282**	20,689,886
Assets limited as to use, less current portion	**43,525,942**	42,742,434
Property and equipment, net	**45,838,997**	45,861,471
Long-term investments	**12,031,012**	12,425,093
Beneficial interest in perpetual trust	**6,053,687**	6,355,445
Cash surrender value of life insurance	**1,248,266**	1,248,266
Total assets	**$ 131,447,186**	$129,322,595

LIABILITIES AND NET ASSETS

Current liabilities		
Accounts payable and other current liabilities	**$ 3,549,385**	$ 3,097,973
Accrued salaries and related accounts	**2,386,134**	2,011,756
Current portion of long-term debt	**618,470**	600,064
Due to related parties	**1,534,198**	318,061
Current portion of estimated third-party payor settlements	**2,700,729**	1,834,624
Total current liabilities	**10,788,916**	7,862,478
Estimated third-party payor settlements, less current portion	**21,155,391**	21,212,078
Interest rate swap	**3,193,584**	1,838,679
Long-term debt, excluding current portion	**19,514,215**	20,052,442
Total liabilities	**54,652,106**	50,965,677
Net assets		
Without donor restrictions	**58,131,841**	59,006,407
With donor restrictions	**18,663,239**	19,350,511
Total net assets	**76,795,080**	78,356,918
Total liabilities and net assets	**$ 131,447,186**	$ 129,322,595

The accompanying notes are an integral part of these consoldiated financial statements.

HUGGINS HOSPITAL AND SUBSIDIARY

Consolidated Statements of Operations

Years Ended September 30, 2019 and 2018

	2019	2018
Revenues, gains and other support without donor restrictions		
Patient service revenue (net of discounts and contractual allowances)	**$ 62,399,259**	$ 60,572,938
Less provision for bad debts	**3,120,778**	3,376,783
Net patient service revenue	**59,278,481**	57,196,155
Other operating revenues	**5,411,552**	4,123,419
Investment income allotted for operations	**564,000**	564,000
Net assets released from restrictions for operating purposes	**48,026**	83,055
Total revenues and gains	**65,302,059**	61,966,629
Expenses		
Salaries, wages, and fringe benefits	**36,548,707**	35,025,019
Supplies	**6,420,917**	5,200,245
Physician fees	**3,834,940**	3,997,199
Other	**10,091,589**	7,982,361
Medicaid enhancement tax	**2,453,191**	2,251,983
Depreciation and amortization	**4,753,881**	4,694,000
Interest	**984,914**	658,801
Total expenses	**65,088,139**	59,809,608
Operating income	**213,920**	2,157,021
Nonoperating gains (losses)		
Contributions	**278,454**	334,967
Development costs	**(173,627)**	(208,300)
Nonoperating investment income	**3,886,039**	1,907,992
Change in value of interest rate swap	**(1,354,905)**	780,845
Pension curtailment loss	**-**	(4,652,215)
Affiliation costs	**(595,187)**	-
Nonoperating gains (losses), net	**2,040,774**	(1,836,711)
Excess of revenues and gains over expenses	**2,254,694**	320,310
Net assets released from restrictions for capital acquisitions	**3,500**	12,095
Net unrealized (losses) gains on investments	**(3,132,760)**	1,066,016
Pension liability adjustment	**-**	6,622,913
(Decrease) increase in net assets without donor restrictions	**$ (874,566)**	$ 8,021,334

The accompanying notes are an integral part of these consoldiated financial statements.

HUGGINS HOSPITAL AND SUBSIDIARY

Consolidated Statements of Changes in Net Assets

Years Ended September 30, 2019 and 2018

	Without Donor Restrictions	With Donor Restrictions	Total
Balances, October 1, 2017	$ 50,985,073	$ 18,010,983	$ 68,996,056
Excess of revenues and gains over expenses	320,310	-	320,310
Contributions	-	1,006,921	1,006,921
Investment income, net of fees	-	200,901	200,901
Net assets released from restrictions for operations	-	(83,055)	(83,055)
Net assets released from restrictions for capital acquisitions	12,095	(12,095)	-
Spending policy allotment	-	(564,000)	(564,000)
Realized gains on sales of investments	-	465,373	465,373
Net unrealized gains on investments	1,066,016	336,753	1,402,769
Pension liability adjustment	6,622,913	-	6,622,913
Change in beneficial interest in perpetual trust	-	(11,270)	(11,270)
Net increase in net assets	8,021,334	1,339,528	9,360,862
Balances, September 30, 2018	59,006,407	19,350,511	78,356,918
Excess of revenues and gains over expenses	**2,254,694**	**-**	**2,254,694**
Contributions	**-**	**60,093**	**60,093**
Investment income, net of fees	**-**	**224,054**	**224,054**
Net assets released from restrictions for operations	**-**	**(48,026)**	**(48,026)**
Net assets released from restrictions for capital acquisitions	**3,500**	**(3,500)**	**-**
Spending policy allotment	**-**	**(564,000)**	**(564,000)**
Realized gains on sales of investments	**-**	**1,527,796**	**1,527,796**
Net unrealized losses on investments	**(3,132,760)**	**(1,581,931)**	**(4,714,691)**
Change in beneficial interest in perpetual trust	**-**	**(301,758)**	**(301,758)**
Net decrease in net assets	**(874,566)**	**(687,272)**	**(1,561,838)**
Balances, September 30, 2019	**$ 58,131,841**	**$ 18,663,239**	**$ 76,795,080**

The accompanying notes are an integral part of these consoldiated financial statements.

HUGGINS HOSPITAL AND SUBSIDIARY

Consolidated Statements of Cash Flows

Years Ended September 30, 2019 and 2018

	2019	2018
Cash flows from operating activities		
Change in net assets	**$ (1,561,838)**	$ 9,360,862
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Change in beneficial interest in perpetual trust	**301,758**	11,270
Depreciation and amortization	**4,834,124**	4,774,243
Provision for bad debts	**3,120,778**	3,376,783
Net realized and unrealized losses (gains) on investments	**41,081**	(3,204,490)
Pension curtailment loss	**-**	4,652,215
Pension liability adjustment	**-**	(6,622,913)
Unrealized loss (gain) on interest rate swap	**1,354,905**	(780,845)
Decrease (increase) in		
Accounts receivable from patients	**(4,487,166)**	(3,780,941)
Other accounts and notes receivable	**1,945,293**	(2,367,409)
Other current assets	**(735,608)**	1,210
Increase (decrease) in		
Accounts payable and other current liabilities	**451,412**	1,065,474
Due to related parties	**1,216,137**	228,705
Accrued salaries and related accounts	**374,378**	275,686
Estimated third-party payor settlements	**809,418**	(60,007)
Accrued pension cost	**-**	(2,029,717)
Net cash provided by operating activities	**7,664,672**	4,900,126
Cash flows from investing activities		
Purchase of property and equipment	**(4,731,407)**	(4,435,095)
Purchase of investments	**(40,489,920)**	(13,076,654)
Proceeds from sale of investments	**40,059,412**	12,855,105
Net cash used by investing activities	**(5,161,915)**	(4,656,644)
Cash flows from financing activities		
Payments on long-term debt	**(600,064)**	(581,655)
Net cash used by financing activities	**(600,064)**	(581,655)
Net increase (decrease) in cash and cash equivalents	**1,902,693**	(338,173)
Cash and cash equivalents, beginning of year	**8,994,916**	9,333,089
Cash and cash equivalents, end of year	**$ 10,897,609**	$ 8,994,916
Supplemental disclosure of cash flow information		
Interest paid	**$ 854,671**	$ 802,604

The accompanying notes are an integral part of these consoldiated financial statements.

Organization

Huggins Hospital (the Hospital) is a not-for-profit Critical Access Hospital (CAH) in Wolfeboro, New Hampshire. The Hospital provides inpatient, outpatient, extended care, assisted living, primary care and emergency care services to residents of East-Central New Hampshire. Huggins Senior Housing, Inc. (HSH) is a wholly-owned subsidiary of the Hospital. HSH is the for-profit management company of a retirement community (Sugar Hill Retirement Community (SHRC)) in Wolfeboro, New Hampshire.

In January 2017, the Hospital became affiliated with Catholic Medical Center (CMC) of Manchester, New Hampshire and Monadnock Community Hospital (MCH) of Peterborough, New Hampshire, under a new organization and parent company, GraniteOne Health (GraniteOne). GraniteOne is a non-profit entity and, as a healthcare system, allows the three hospitals to enhance collaboration, strengthen clinical partnerships, and meet the health needs of the communities it serves through high-quality care and a seamless patient experience. The Hospital has two representatives on the thirteen-member Board of Trustees of GraniteOne.

On September 30, 2019, GraniteOne, CMC, CMC Healthcare System ("CMCHS"), certain subsidiaries of CMCHS, MCH and the Hospital entered into a Combination Agreement (the "Agreement") with Dartmouth-Hitchcock Health ("D-HH") to combine GraniteOne and D-HH and its members into a more fully integrated healthcare delivery system. Pursuant to the terms of the Agreement, the parties intend to revise D-HH's corporate name to Dartmouth-Hitchcock Health GraniteOne ("D-HH GO"), which will continue to serve as the sole corporate member of the existing D-HH System Members (Mary Hitchcock Memorial Health and Dartmouth-Hitchcock Clinic, New London Hospital, Cheshire Medical Center, Mt. Ascutney Hospital and Health Center, Alice Peck Day Memorial Hospital and Visiting Nurse and Hospice for Vermont and New Hampshire), and which will be substituted for GraniteOne as the sole corporate member of MCH and the Hospital and as co-member, of CMC and certain subsidiaries of CMCHS (the "Combination"). The overarching goal of the Combination is to create a New Hampshire-based, integrated and regionally distributed health care delivery system that better serves its patients and communities. While CMCHS will not be a component of the D-HH GO System, it will continue to serve as the corporate vehicle through which the Bishop of the Diocese of Manchester (the "Bishop") ensures CMC's adherence to the Ethical and Religious Directives for Catholic Health Care Services. Neither CMCHS nor the Bishop will have authority over any other D-HH GO System Member, including MCH and the Hospital. Subject to certain rights reserved to the Bishop and CMCHS with respect to CMC and the CMCHS Subsidiaries, D-HH GO will reserve to itself certain approval and initiation powers over the governance, financial, programmatic, administrative, and strategic decisions of D-HH GO System Members.

On December 30, 2019, GraniteOne, CMC, MCH and the Hospital submitted a Joint Notice of Change of Control to the New Hampshire Attorney General, Director of Charitable Trusts pursuant to New Hampshire RSA 7:19-b beginning the regulatory review and approval process of the Combination. If all necessary approvals are obtained and closing conditions satisfied, D-HH GO will consist of a major academic medical center offering tertiary and quaternary services, an acute care community hospital in an urban setting (CMC), an acute care community hospital in a rural setting (Cheshire), five rural CAH's (NLH, MAHHC, APD, MCH and the Hospital) a post-acute home health and hospice provider (VNH), and nearly 1,800 employed and affiliated primary and specialty care physicians. D-HH GO System Members will combine their resources to offer a broader array of inpatient, outpatient and ambulatory services.

1. Summary of Significant Accounting Policies

Principles of Consolidation

The consolidated financial statements represent the parent and subsidiary activities after the elimination of all material intercompany balances and activity.

Basis of Presentation

Net assets and revenues, expenses, gains, and losses are classified based on the existence or absence of donor-imposed restrictions in accordance with Financial Accounting Standards Board (FASB) Accounting Standards Codification Topic (ASC) 958, *Not-For-Profit Entities*. Under FASB ASC 958 and FASB ASC 954, *Health Care Entities*, all not-for-profit healthcare organizations are required to provide a balance sheet, a statement of operations, a statement of changes in net assets, and a statement of cash flows. FASB ASC 954 requires reporting amounts for an organization's total assets, liabilities, and net assets in a balance sheet; reporting the change in an organization's net assets in statements of operations and changes in net assets; and reporting the change in its cash and cash equivalents in a statement of cash flows, according to the following net asset classification:

Net assets without donor restrictions: Net assets that are not subject to donor-imposed restrictions and may be expended for any purpose in performing the primary objectives of the Hospital. These net assets may be used at the discretion of the Hospital's management and the Board of Trustees (Board).

Net assets with donor restrictions: Net assets subject to stipulations imposed by donors and grantors. Some donor restrictions are temporary in nature; those restrictions will be met by actions of the Hospital or by the passage of time. Other donor restrictions are perpetual in nature, whereby the donor has stipulated the funds be maintained in perpetuity.

Donor-restricted contributions are reported as increases in net assets with donor restrictions. When a restriction expires, net assets are reclassified from net assets with donor restrictions to net assets without donor restrictions in the statements of operations and changes in net assets.

Newly Adopted Accounting Pronouncement

In August 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2016-14, *Presentation of Financial Statements of Not-for-Profit Entities* (Topic 958), which makes targeted changes to the not-for-profit financial reporting model. The ASU marks the completion of the first phase of a larger project aimed at improving not-for-profit financial reporting. Under the ASU, net asset reporting will be streamlined and clarified. The previous three category classification of net assets is replaced with a simplified model that combines temporarily restricted and permanently restricted into a single category called “net assets with donor restrictions.” The guidance for classifying deficiencies in endowment funds and on accounting for the lapsing of restrictions on gifts to acquire property and equipment has also been simplified and clarified. New disclosures will highlight restrictions on the use of resources that

make otherwise liquid assets unavailable for meeting near-term financial requirements. The ASU also imposes several new requirements related to reporting expenses. The ASU is effective for the Hospital for the year ended September 30, 2019. Required disclosures for 2018 are also included in these financial statements.

Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles (U.S. GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents

Cash and cash equivalents include certain investments in highly liquid debt instruments with original maturities of three months or less.

Accounts Receivable from Patients

Patient accounts receivable are stated at the amount management expects to collect from outstanding balances. Management provides for probable uncollectible amounts through a charge to operations and a credit to a valuation allowance based on its assessment of individual accounts and historical adjustments. Balances that are still outstanding after management has used reasonable collection efforts are written off through a charge to the valuation allowance and a credit to patient accounts receivable.

In evaluating the collectibility of accounts receivable, the Hospital analyzes past results and identifies trends for each major payor source of revenue for the purpose of estimating the appropriate amounts for the allowance for doubtful accounts and the provision for bad debts. Data in each major payor source are regularly reviewed to evaluate the adequacy of the allowance for doubtful accounts. Specifically, for receivables relating to services provided to patients having third-party coverage, an allowance for doubtful accounts and a corresponding provision for bad debts are established at varying levels based on the age of the receivables and payor source. For receivables relating to self-pay patients, a provision for doubtful accounts and corresponding allowance for doubtful accounts is made in the period services are rendered based on experience indicating the inability or unwillingness of patients to pay amounts for which they are financially responsible. Actual write-offs are charged against the allowance for doubtful accounts.

The allowance for doubtful accounts was approximately $2,115,000 and $2,640,000 at September 30, 2019 and 2018, respectively, and relates entirely to self-pay accounts. Self-pay accounts receivable were approximately $2,975,000 and $3,626,000 at September 30, 2019 and 2018, respectively. The decrease in the allowance is attributed to the decrease in self-pay accounts receivable.

Investments

Investments in equity securities with readily determinable fair values, and all investments in debt securities, are recorded at fair value. Investment income from funded depreciation, Board-designated investments, and investments without donor restrictions are reported as nonoperating investment income. The amount allotted for operations per the Hospital's spending policy is included in operating revenues.

Realized gains or losses on the sale of investments are determined by use of the average cost method. Unrealized gains and losses on investments are excluded from the excess of revenues and gains over expenses, and are reported as an increase or decrease in net assets, except that declines in fair value that are judged to be other than temporary are reported as realized losses. No unrealized losses were deemed to be other than temporary in 2019 and 2018.

Investments in general are exposed to various risks, such as interest rate, credit, and overall market volatility. As such, it is at least reasonably possible that changes in the values of investments will occur in the near term and that such changes could materially affect the amounts reported in the consolidated balance sheets.

Donor-Restricted Gifts

Unconditional promises to give cash and other assets to the Hospital are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received. The gifts are reported as support with donor restrictions if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, net assets with donor restrictions are reclassified as net assets without donor restrictions and reported in the statements of operations as net assets released from restrictions.

Assets Limited as to Use

Assets limited as to use include designated assets set aside by the Board of Trustees for future capital improvements and funds held by trustees under the revenue bond agreement. Board-designated funds are controlled by the Board and it may, at its discretion, subsequently use them for other purposes.

Interest Rate Swap

The Hospital uses an interest rate swap contract to eliminate the cash flow exposure of interest rate movements on variable-rate debt. The Hospital has adopted FASB ASC 815, *Derivatives and Hedging*, to account for its interest rate swap contract. The interest rate swap contract has not been designated as a cash flow hedge. Unrealized gains and losses on the fair value of derivative financial instruments not designated as cash flow hedges are required to be included in the performance indicator. As a result, the changes in fair value of the interest rate swap for 2019 and 2018 have been included in the excess of revenues and gains over expenses. The Hospital expects to hold the swap until its maturity, at which point unrealized gains or losses will be zero.

Property and Equipment

Property and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method.

Gifts of long-lived assets such as land, buildings, or equipment are reported as support without donor restrictions, and are excluded from the excess of revenues and gains over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

Deferred Financing Costs

The costs incurred to obtain long-term financing are being amortized by the straight-line method over the repayment period of the related debt. The costs are included in long-term debt in the balance sheet.

Charity Care

The Hospital provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue.

Excess of Revenues and Gains Over Expenses

Changes in net assets without donor restrictions which are excluded from the excess of revenues and gains over expenses, consistent with industry practice, include unrealized gains and temporary unrealized losses on investments, pension liability adjustments and contributions of long-lived assets (including assets acquired using contributions which, by donor restriction, were to be used for the purposes of acquiring such assets).

Net Patient Service Revenue

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

Employee Fringe Benefits

The Hospital has an "earned time" plan under which each employee earns paid leave for each period worked. These hours of paid leave may be used for vacations, holidays, or illnesses. Hours earned, but not used, are vested with the employee. Employees can vest up to 368 hours. The Hospital accrues a liability for such paid leave as it is earned.

Income Taxes

The Internal Revenue Service currently recognizes the Hospital as an exempt organization under Internal Revenue Code Section 501(c)(3). HSH is a for-profit corporation and, as such, is subject to federal and state taxes. Taxes were not material in 2019 or 2018.

Reclassifications

Certain amounts in the 2018 consolidated financial statements have been reclassified to conform to the 2019 presentation. Estimated third-party payor settlements related to disproportionate share hospital (DSH) and certain Medicare settlements have been reclassified as long-term due to the unresolved issues at the federal level.

Subsequent Events

For purposes of the preparation of these financial statements in conformity with U.S. GAAP, the Hospital has considered transactions or events occurring through February 3. 2020, which was the date the financial statements were available to be issued.

2. Net Patient Service Revenue

The Hospital has agreements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows:

Medicare

Effective June 1, 2005, the Hospital was granted CAH status. With CAH designation, the Hospital is reimbursed at 101% of allowable costs for its inpatient and outpatient services provided to Medicare patients. The 101% is currently reduced by a federal sequestration of 2%. The Hospital is reimbursed at tentative rates with final settlement determined after submission of annual cost reports by the Hospital and audits thereof by the Medicare fiscal intermediary. The Hospital's Medicare cost reports have been settled by the Medicare fiscal intermediary through September 30, 2013.

Medicaid

Inpatient services rendered to Medicaid program beneficiaries are reimbursed at prospectively determined rates per day of hospitalization. The prospectively determined per-diem rates are not subject to retroactive adjustment. Outpatient services rendered to Medicaid program beneficiaries are reimbursed under a cost reimbursement methodology. The Hospital is reimbursed at a tentative rate with final settlement determined after submission of annual cost reports by the Hospital and audits thereof by the fiscal intermediary. The Hospital's Medicaid cost reports have been settled by the fiscal intermediary through September 30, 2013.

Medicaid disproportionate share hospital (DSH) payments provide financial assistance to hospitals that serve a large number of low-income patients. The federal government distributes federal DSH funds to each state based on a statutory formula. The states, in turn, distribute their portion of the DSH funding among qualifying hospitals. The states are to use their federal DSH allotments to help cover costs of hospitals that provide care to low-income patients when those costs are not covered by other payors. The State of New Hampshire's distribution of DSH monies to the hospitals is subject to audit by the Centers for Medicare & Medicaid Services. Amounts recorded by the Hospital are therefore subject to change. The disproportionate share payment revenue was estimated to be $2,774,000 and $2,821,000 for 2019 and 2018, respectively, and was recorded as an increase in net patient service revenue. Because the methodologies used to determine disproportionate share payments remain unsettled, the Hospital has established partial reserves on the amounts received.

Revenues from the Medicare and Medicaid programs accounted for approximately 50% and 10%, respectively, of the Hospital's patient revenue for the year ended September 30, 2019, and approximately 50% and 9%, respectively, for the year ended September 30, 2018. Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Net patient service revenue increased approximately $2,405,000 and $1,716,000 in 2019 and 2018, respectively, due to adjustments to settled amounts for which there was uncertainty of interpretation of the applicable regulations.

Anthem Blue Cross

Inpatient and outpatient services rendered to Anthem Blue Cross subscribers are reimbursed at submitted charges less a negotiated discount. The amounts paid to the Hospital are not subject to any retroactive adjustments.

Patient service revenue and contractual and other allowances consisted of the following for the years ended September 30:

	2019	2018
Patient services		
Inpatient	**$ 19,867,633**	$ 20,142,507
Outpatient	**102,673,377**	95,998,277
	122,541,010	116,140,784
Less Medicare allowances	**29,027,178**	29,118,869
Less other payor allowances	**29,858,347**	25,214,022
Less free care and charity allowances	**1,256,226**	1,234,955
Patient service revenue (net of discounts and contractual allowances)	**62,399,259**	60,572,938
Less provision for bad debts	**3,120,778**	3,376,783
Net patient service revenue	**$ 59,278,481**	$ 57,196,155

Revenue related to self-pay patients was approximately $2,714,000 and $2,855,000 for the years ended September 30, 2019 and 2018, respectively.

3. Charity Care

The Hospital maintains records to identify and monitor the level of charity care it provides. These records include the amount of charges foregone for services and supplies furnished under its charity care policy, as well as the estimated cost of those services and supplies and equivalent service statistics. The following information measures the level of charity care provided during the years ended September 30:

	2019	2018
Charges forgone, based on established rates	**$ 1,256,226**	$ 1,234,955
Estimated costs and expenses incurred to provide charity care	**$ 664,000**	$ 634,000
Equivalent percentage of charity care charges to all Hospital patient charges	**1.03 %**	1.06 %

Costs of providing charity care services have been estimated based on the relationship of charges for these services to total expenses.

4. Availability and Liquidity of Financial Assets

As of September 30, 2019 and 2018, the Hospital has working capital of $10,897,609 and $8,994,916, respectively, and average days (based on normal expenditures) cash and cash equivalents on hand of 66 and 60, respectively.

The Hospital's debt covenants require the Hospital to maintain financial assets to 100 days of operating expenses. The Hospital budgets to maintain 345 days of operating expenses. As part of the Hospital's liquidity plan, cash in excess of daily requirements is invested in short-term investments.

Financial assets and liquidity resources available within one year for general expenditure, such as operating expenses, scheduled principle payments on debt, and capital construction costs not financed with debt, were as follows as of September 30:

	2019	2018
Cash and cash equivalents	**$ 10,897,609**	$ 8,994,916
Patient accounts receivable, net	**8,802,983**	7,436,595
Other accounts and notes receivable	**1,500,892**	3,446,185
Financial assets available to meet cash needs for general expenditures within one year	**$ 21,201,484**	$ 19,877,696

The Hospital has $43,525,942 and $42,742,434 at September 20, 2019 and 2018, respectively, that are designated assets set aside by the Board for future capital improvements. These assets limited as to use are not available for general expenditure within the next year; however, the internally designated amounts could be made available, if necessary.

5. Investments

Assets Limited as to Use

The composition of assets limited as to use as of September 30, 2019 and 2018 is set forth in the following table. Investments are stated at fair value.

	2019	2018
Cash and cash equivalents	**$ 3,230,179**	$ 3,446,076
Mutual funds	**25,983,970**	18,877,690
Equity securities	**-**	8,055,498
Government securities	**6,318,782**	4,970,681
Corporate notes and bonds	**7,386,908**	6,746,506
Alternative investments	**606,103**	645,983
	$ 43,525,942	$ 42,742,434

Other Investments

Other investments stated at fair value as of September 30 include:

	2019	2018
Cash and cash equivalents	**$ 362,794**	$ 69,431
Mutual funds	**7,164,424**	4,074,009
Equity securities	**284,510**	4,199,987
Government securities	**1,956,030**	1,832,229
Corporate notes and bonds	**1,847,657**	1,811,404
Alternative investments	**340,997**	363,433
Other investments	**74,600**	74,600
Total long-term investments	**12,031,012**	12,425,093
Beneficial interest in perpetual trust	**6,053,687**	6,355,445
	$ 18,084,699	$ 18,780,538

Investment income (losses) consist of the following for the years ended September 30:

	2019	2018
Income		
Investment income	**$ 1,599,620**	$ 1,355,990
Net realized gains on sales of securities	**4,673,915**	1,801,721
	$ 6,273,535	$ 3,157,711
Investment income is reported as follows:		
Nonoperating investment income	**$ 3,886,039**	$ 1,907,992
Investment income allotted for operations	**564,000**	564,000
Included in other operating revenues	**71,646**	19,445
Restricted investment income	**224,054**	200,901
Restricted realized gains	**1,527,796**	465,373
	$ 6,273,535	$ 3,157,711
Other changes in net assets		
Net unrealized (losses) gains		
- without donor restrictions	**$ (3,132,760)**	$ 1,066,016
- with donor restrictions	**(1,581,931)**	336,753
	$ (4,714,691)	$ 1,402,769

Total gross unrealized losses sustained for less than twelve months were approximately $190,000 on investments held at September 30, 2019. In the opinion of management, no individual unrealized loss represents an other-than-temporary impairment. The Hospital has both the intent and the ability to hold these securities for the time necessary to recover their cost.

6. Endowment

The Hospital's endowment primarily consists of donor-restricted endowment funds. As required by U.S. GAAP, net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions.

The Organization has interpreted the State of New Hampshire Uniform Prudent Management of Institutional Funds Act (UPMIFA) such that the Board of Trustees is allowed to appropriate for expenditure for the uses and purposes for which the endowment fund is established, unless otherwise specified by the donor, so much of the net appreciation, realized and unrealized, in the fair value of the assets of the endowment fund over the historic dollar value of the fund as is prudent. In so doing, the Board must consider the long- and short-term needs of the Hospital in carrying out its purpose, its present and anticipated financial requirements, expected total return on its investments, price level trends, and general economic conditions. Appreciation over the amounts expended is retained in net assets with donor restrictions.

Changes in endowment funds for the years ended September 30, 2019 and 2018 are as follows:

Endowment funds, October 1, 2017	$ 11,550,011
Interest and dividends, net of fees	200,901
Realized gains on investments	465,373
Unrealized gains on investments	336,753
Total investment gain	1,003,027
Spending policy allotment	(564,000)
Endowment funds, September 30, 2018	11,989,038
Interest and dividends, net of fees	**224,054**
Realized gains on investments	**1,527,796**
Unrealized losses on investments	**(1,581,931)**
Total investment gain	**169,919**
Spending policy allotment	**(564,000)**
Endowment funds, September 30, 2019	**$ 11,594,957**

Investment Policy and Strategies Employed for Achieving Investment Objectives

The Hospital's investment strategy is for long-term growth and tolerance for a fair amount of volatility to achieve this growth. The investment time horizon is five years or more. The overall objective is to provide a strategic mix of asset classes that produce the highest expected return while controlling risk. The Hospital's target investment allocation is 55% global equities, 35% fixed income, and 10% alternatives. Investment advisors are prohibited from purchasing hedge fund and private equity investments, without prior approval of the Hospital.

Spending Policy

Effective October 1, 2009, each year a calculation is made to determine the maximum amount of money that can be withdrawn from the long-term portfolio to be used for each donor-restricted and Board-designated purpose. The annual amount available for spending is not to exceed 7% of the fair market value calculated on the basis of market values determined at least quarterly and averaged over a period of not less than three years immediately preceding the year in which the appropriation for the expenditure is made. The amount distributed under the spending policy was $564,000 for 2019 and 2018. Investment income, within the spending policy guidelines, is reported in revenues and gains in the accompanying financial statements.

Funds with Deficiencies

From time to time, the fair value of assets associated with individual donor restricted endowment funds may fall below the level that the donor or UPMIFA requires the Hospital to retain as a fund of perpetual duration. The Hospital has interpreted UPMIFA to permit spending from funds with deficiencies in accordance with the prudent measures required under the UPMIFA. There were no such deficiencies as of September 30, 2019 and 2018.

7. Fair Value Measurements

U.S. GAAP established a fair value hierarchy that distinguishes between market participant assumptions based on market data obtained from sources independent of the reporting entity (observable inputs classified within Levels 1 and 2 of the hierarchy) and the reporting entity's own assumptions about market participant assumptions (unobservable inputs classified within Level 3 of the hierarchy):

Level 1: Quoted prices (unadjusted) for identical assets or liabilities in active markets that the entity has the ability to access as of the measurement date.

Level 2: Significant other observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities, quoted prices in markets that are not active, and other inputs that are observable or can be corroborated by observable market data.

Level 3: Significant unobservable inputs that reflect an entity's own assumptions about the assumptions that market participants would use in pricing an asset or liability.

Assets and liabilities measured at fair value on a recurring basis are summarized below.

	Fair Value Measurements at September 30, 2019			
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets:				
Assets limited as to use				
Cash and cash equivalents	$ 3,230,179	$ 3,230,179	$ -	$ -
Fixed income				
U.S. Government bonds	6,318,782	6,318,782	-	-
Corporate notes and bonds	7,386,908	-	7,386,908	-
Total fixed income	13,705,690	6,318,782	7,386,908	-
Mutual funds	25,983,970	25,983,970	-	-
	42,919,839	$ 35,532,931	$ 7,386,908	$ -
Investments measured at net asset value (NAV)	606,103			
Total assets limited as to use	$ 43,525,942			
Other investments				
Cash and cash equivalents	$ 362,794	$ 362,794	$ -	$ -
Fixed income				
Government securities	1,956,030	1,956,030	-	-
Corporate notes and bonds	1,847,657	-	1,847,657	-
Total fixed income	3,803,687	1,956,030	1,847,657	-
Equity securities	284,510	284,510	-	-
Mutual funds	7,164,424	7,164,424	-	-
Other investments	74,600	-	-	74,600
	11,690,015	$ 9,767,758	$ 1,847,657	$ 74,600
Investments measured at NAV	340,997			
Total long-term investments	$ 12,031,012			
Beneficial interest in perpetual trust	$ 6,053,687	$ -	$ -	$ 6,053,687
Liabilities:				
Interest rate swap	$ 3,193,584	$ -	$ 3,193,584	$ -

	Fair Value Measurements at September 30, 2018			
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets:				
Assets limited as to use				
Cash and cash equivalents	$ 3,446,076	$ 3,446,076	$ -	$ -
Fixed income				
U.S. Government bonds	4,970,681	4,970,681	-	-
Corporate notes and bonds	6,746,506	-	6,746,506	-
Total fixed income	11,717,187	4,970,681	6,746,506	-
Equity securities	8,055,498	8,055,498	-	-
Mutual funds	18,877,690	18,877,690	-	-
	42,096,451	$ 35,349,945	$ 6,746,506	$ -
Investments measured at NAV	645,983			
Total assets limited as to use	$ 42,742,434			
Other investments				
Cash and cash equivalents	$ 69,431	$ 69,431	$ -	$ -
Fixed income				
Government securities	1,832,229	1,832,229	-	-
Corporate notes and bonds	1,811,404	-	1,811,404	-
Total fixed income	3,643,633	1,832,229	1,811,404	-
Equity securities	4,199,987	4,199,987	-	-
Mutual funds	4,074,009	4,074,009	-	-
Other investments	74,600	-	-	74,600
	12,061,660	$ 10,175,656	$ 1,811,404	$ 74,600
Investments measured at NAV	363,433			
Total long-term investments	$ 12,425,093			
Beneficial interest in perpetual trust	$ 6,355,445	$ -	$ -	$ 6,355,445
Liabilities:				
Interest rate swap	$ 1,838,679	$ -	$ 1,838,679	$ -
Investments - held by defined benefit pension plan (Note 13):				
Cash and cash equivalents	$ 187,097	$ 187,097	$ -	$ -
Total	$ 187,097	$ 187,097	$ -	$ -

The fair value of Level 2 assets and liabilities is primarily based on market prices of comparable securities, interest rates, and credit ratings. These techniques are significantly affected by the assumptions used, including the discount rate and estimates of future cash flows. Accordingly, the fair value estimates may not be realized in an immediate settlement of the instrument.

As the beneficial interest in perpetual trust is not readily available to the Hospital, the interest is classified as Level 3 and recorded based upon the fair value of the underlying assets.

Changes in fair value of assets classified as Level 3 are comprised of the following for the years ended September 30:

	Beneficial Interest
Balance, October 1, 2017	$ 6,366,715
Change in value	(11,270)
Balance, September 30, 2018	6,355,445
Change in value	**(301,758)**
Balance, September 30, 2019	**$ 6,053,687**

The following table sets forth a summary of the Hospital's investments valued using a reported NAV at September 30, 2019:

Investment	Fair Value Estimated Using NAV Per Share at September 30: **2019**	2018	Redemption Frequency	Other Redemption Restrictions	Redemption Notice Period
The Optima Discretionary Macro Fund Ltd Offshore Multi-Manager	**$ 947,100**	$ 1,009,416	Quarterly	Purchased or redeemed at the NAV on the first business day of each month	Subject to 65 days' prior written notice
	$ 947,100	$ 1,009,416			

8. Property and Equipment

The major categories of property and equipment are as follows as of September 30:

	2019	2018
Land	**$ 1,828,322**	$ 1,828,322
Land improvements	**6,731,373**	6,251,093
Buildings	**54,452,210**	54,139,920
Building services equipment	**13,288,422**	10,534,541
Major moveable equipment	**13,009,470**	12,857,972
Construction in progress	**3,737,546**	2,704,087
	93,047,343	88,315,935
Less accumulated depreciation	**47,208,346**	42,454,464
	$ 45,838,997	$ 45,861,471

During 2018, the Hospital began the installation and implementation of new enterprise resource planning and electronic health record systems. At September 30, 2019, the Hospital had approximately $2,180,000 of costs in construction in progress related to this project. Total estimated costs for completion are $3.5 million and this project is expected to be completed in Spring 2020. The Hospital also began a renovation project of its Medical Arts Center for approximately $3 million, which is expected to be completed during 2020.

9. Long-Term Debt

Long-term debt consists of the following at September 30:

	2019	2018
New Hampshire Health and Education Facilities Authority (NHHEFA) (Huggins Hospital Issue) Series 2017A 2.59% fixed rate direct placement bonds payable in annual installments ranging from $342,439 in 2020 to $671,000 in 2046; collateralized by gross revenues and substantially all assets of the Hospital	**$ 13,721,623**	$ 14,055,318
NHHEFA (Huggins Hospital Issue) Series 2017B variable rate (3.593% at September 30, 2019) direct placement bonds payable in annual installments ranging from $276,031 in 2020 to $776,358 in 2046; collateralized by gross revenues and substantially all assets of the Hospital	**8,637,813**	8,904,182
Total long-term debt before unamortized debt issuance costs	**22,359,436**	22,959,500
Unamortized deferred financing costs	**(2,226,751)**	(2,306,994)
Total long-term debt	**20,132,685**	20,652,506
Less current portion	**618,470**	600,064
Long-term debt, excluding current portion	**$ 19,514,215**	$ 20,052,442

Principal maturities are as follows:

2020	$ 618,470
2021	639,445
2022	659,252
2023	680,380
2024	701,665
Thereafter	19,060,224
	$ 22,359,436

Under its bond agreements with NHHEFA, the Hospital must meet certain restrictive loan covenants. At September 30, 2019, the Hospital was in compliance with its financial covenants related to the bond agreements.

Interest Rate Swap

In connection with the issuance of the 2007 bonds, the Hospital entered into an interest rate swap agreement. The swap agreement's notional amount was $8,955,000 and $9,105,000 at September 30, 2019 and 2018, respectively. The swap terminates on October 1, 2042. The Hospital pays a fixed rate of 3.6175% and receives a variable rate of 68% of USD-LIBOR-BBA. The Hospital records the interest rate swap at fair value, and has recorded a liability of $3,193,584 and $1,838,679 as of September 30, 2019 and 2018, respectively.

10. Related Parties

As a member of GraniteOne Health, the Hospital shares in various services with the other member hospitals and the parent. For the years ended September 30, 2019 and 2018, the Hospital billed Catholic Medical Center $43,310 and $49,879, respectively, and was billed $1,868,892 and $846,662, respectively, in shared services. The Hospital also was charged a management fee of $106,725 and $92,585 which is included in amounts due to related parties at September 30, 2019 and 2018, respectively.

The Hospital owns the land on which SHRC is built and leases it to SHRC. The rental fee increased from $2,469 per month in 2018 to $2,516 per month in 2019. SHRC paid HSH management fees of $70,325 and $92,361 for the years ended 2019 and 2018, respectively.

11. Commitments and Contingencies

The Hospital carries malpractice insurance coverage under a claims-made policy. Should the claims-made policy not be renewed or replaced with equivalent insurance, claims based on occurrences during its term, but reported subsequently, will be uninsured. The Hospital intends to renew its coverable on a claims-made basis and has no reason to believe that it may be prevented from renewing such coverage. The Hospital is subject to complaints, claims and litigation due to potential claims which arise in the normal course of business. U.S. GAAP requires the Hospital to accrue the ultimate cost of malpractice claims when the incident that gives rise to the claim occurs, without consideration of insurance recoveries. Expected recoveries are presented as a separate asset. The Hospital has evaluated its exposure to losses arising from potential claims and has properly accounted for them in the consolidated financial statements as of September 30, 2019 and 2018.

The Hospital leases various equipment and facilities under operating leases expiring at various dates through December 2023. Total rental expense in 2019 and 2018 for all operating leases was approximately $260,000 and $248,000, respectively.

The following is a schedule by year of future minimum lease payments under operating leases as of September 30, 2019 that have initial or remaining lease terms in excess of one year.

Year Ending September 30	Amount
2020	$ 172,000
2021	40,000
2022	28,000
2023	28,000
	$ 268,000

12. Net Assets with Donor Restrictions

Net assets with donor restrictions are available for the following purposes or periods:

	2019	2018
Funds subject to use or time restriction:		
Capital acquisitions	**$ 992,704**	$ 968,939
Adult daycare	**8,708**	4,098
Health education	**420**	20,223
Indigent care	**12,763**	12,768
Net appreciation of funds of perpetual duration:		
Healthcare services	**7,426,848**	7,788,826
Indigent care	**658,097**	690,200
	9,099,540	9,485,054
Funds of perpetual duration:		
Endowment funds	**3,510,012**	3,510,012
Beneficial interest in perpetual trust	**6,053,687**	6,355,445
	9,563,699	9,865,457
	$ 18,663,239	$ 19,350,511

The Hospital is an income beneficiary of a perpetual trust controlled by an unrelated third-party trustee. The beneficial interest in the assets of the trust is included in the Hospital's consolidated financial statements as net assets with donor restrictions. Income is distributed in accordance with the trust documents and is included in investment return. Trust income distributed to the Hospital for the years ended September 30, 2019 and 2018 was $256,825 and $266,502, respectively, and is not restricted.

13. Retirement Plans

Beginning July 2005, the Hospital sponsors a contributory defined contribution plan available to substantially all employees. The Hospital's policy under the defined contribution plan is to fund its portion of amounts due under the plan on a current basis and to recognize expense as incurred. Expense related to this plan for the years ended September 30, 2019 and 2018 approximated $799,900 and $731,900, respectively.

The Hospital sponsored a defined benefit pension plan that covered substantially all employees. In June 2011, the Board of Trustees voted to curtail benefits under the defined benefit plan effective October 1, 2011. All benefits for active employees became fully vested at that time. In November 2017, the Hospital voted to terminate the defined benefit pension plan. The plan was fully funded and settled in August 2018.

The following table sets forth the funded status of the defined benefit plan and amounts recognized in the Hospital's consolidated financial statements as of and for the year ended September 30, 2018:

Change in projected benefit obligation:	
Benefit obligation, beginning of year	$ 17,517,632
Interest cost	583,966
Actuarial gain	(777,070)
Benefits paid	(505,327)
Gain on settlement	(736,461)
Plan settlement	(16,082,740)
Benefit obligation, end of year	$ -
Change in plan assets	
Fair value of plan assets, beginning of year	$ 13,517,217
Actual return on plan assets	27,947
Employer contributions	3,230,000
Benefits paid	(505,327)
Plan settlement	(16,082,740)
Fair value of plan assets, end of year	$ 187,097
Funded status - accrued asset	$ 187,097

The incremental increase in the amounts recognized in other changes in net assets without donor restrictions was $6,622,913 in 2018. This amount has been reflected outside the excess of revenues and gains over expenses in the consolidated statements of operations.

Net pension cost for the Plan included the following components for the year ended September 30, 2018:

Interest cost on projected benefit obligation	$ 583,966
Expected return on Plan assets	(148,427)
Amortization of net loss	577,647
Settlement expense	4,652,215
Net periodic pension benefit cost	$ 5,665,401

14. Concentrations of Credit Risk

The Hospital has cash balances in financial institutions that exceed federal depository insurance limits. However, management believes that credit risk related to these investments is minimal. The Hospital has not experienced any losses in such accounts.

The Hospital grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors was as follows as of September 30:

	2019	2018
Medicare	**38 %**	42 %
Medicaid	**7**	6
Anthem Blue Cross	**12**	8
Other third-party payors	**26**	21
Patients	**17**	23
	100 %	100 %

15. Functional Expenses

The statements of operations report certain expense categories that are attributable to both healthcare services and support functions. Therefore, these expenses require an allocation on a reasonable basis that is consistently applied. Fringe benefits are allocated based on salaries and wages, and depreciation, interest, utilities, and equipment are allocated based on square footage and location. Expenses related to providing healthcare and support services are as follows for the year ended September 30, 2019:

	Program Services	General and Administrative	Fundraising	Total
Salaries, wages, and fringe benefits	$ 26,431,136	$ 9,980,397	$ 137,174	$ 36,548,707
Supplies	5,383,356	1,037,561	-	6,420,917
Physician fees	3,834,940	-	-	3,834,940
Medicaid enhancement tax	2,453,191	-	-	2,453,191
Depreciation and amortization	2,757,252	1,996,629	-	4,753,881
Interest	571,250	413,664	-	984,914
Contracted services	3,127,510	-	-	3,127,510
Other professional services	1,199,259	900,196	83,806	2,183,261
Utilities	1,098,703	795,613	-	1,894,316
Insurance	390,427	417,622	-	808,049
Minor equipment costs	480,977	348,294	-	829,271
Other	636,432	611,230	1,520	1,249,182
	$ 48,364,433	$ 16,501,206	$ 222,500	$ 65,088,139

SUPPLEMENTARY INFORMATION

HUGGINS HOSPITAL AND SUBSIDIARY

Consolidating Balance Sheet

September 30, 2019

ASSETS

	Huggins Hospital	Huggins Senior Housing	Eliminations	Consolidated
Current assets				
Cash and cash equivalents	$ 10,615,033	$ 282,576	$ -	**$ 10,897,609**
Accounts receivable from patients, net	8,802,983	-	-	**8,802,983**
Due from related party	700,000	-	(700,000)	**-**
Other accounts and notes receivable	1,489,082	11,810	-	**1,500,892**
Other current assets	1,087,758	460,040	-	**1,547,798**
Total current assets	22,694,856	754,426	(700,000)	**22,749,282**
Assets limited as to use	43,525,942	-	-	**43,525,942**
Property and equipment, net	45,582,298	256,699	-	**45,838,997**
Long-term investments	12,031,012	-	-	**12,031,012**
Beneficial interest in perpetual trust	6,053,687	-	-	**6,053,687**
Cash surrender value of life insurance	1,248,266	-	-	**1,248,266**
Due from subsidiary	-	-	-	**-**
Total assets	$ 131,136,061	$ 1,011,125	$ (700,000)	**$ 131,447,186**

LIABILITIES AND NET ASSETS (DEFICIT)

Current liabilities				
Accounts payable and other current liabilities	$ 3,107,653	$ 441,732	$ -	**$ 3,549,385**
Accrued salaries and related accounts	2,386,134	-	-	**2,386,134**
Current portion of long-term debt	618,470	-	-	**618,470**
Due to related parties	1,534,198	-	-	**1,534,198**
Current portion Estimated third-party payor settlements	2,700,729	-	-	**2,700,729**
Total current liabilities	10,347,184	441,732	-	**10,788,916**
Current portion of estimated third-party payor settlements	21,155,391	-	-	**21,155,391**
Interest rate swap	3,193,584	-	-	**3,193,584**
Long-term debt, excluding current portion	19,514,215	-	-	**19,514,215**
Due to subsidiary	-	700,000	(700,000)	**-**
Total liabilities	54,210,374	1,141,732	(700,000)	**54,652,106**
Net assets (deficit)				
Without donor restrictions	58,262,448	(130,607)	-	**58,131,841**
With donor restrictions	18,663,239	-	-	**18,663,239**
Total net assets (deficit)	76,925,687	(130,607)	-	**76,795,080**
Total liabilities and net assets (deficit)	$ 131,136,061	$ 1,011,125	$ (700,000)	**$ 131,447,186**

HUGGINS HOSPITAL AND SUBSIDIARY

Consolidating Statement of Operations

Year Ended September 30, 2019

	Huggins Hospital	Huggins Senior Housing	Eliminations	Consolidated
Revenues, gains, and other support without donor restrictions				
Patient service revenue (net of discounts and contractual allowances)	$ 62,399,259	$ -	$ -	**$ 62,399,259**
Less provision for bad debts	3,120,778	-	-	**3,120,778**
Net patient service revenue	59,278,481	-	-	**59,278,481**
Other operating revenues	5,066,494	355,058	(10,000)	**5,411,552**
Investment income allotted for operations	564,000	-	-	**564,000**
Net assets released from restrictions for operating purposes	48,026	-	-	**48,026**
Total revenues and gains	64,957,001	355,058	(10,000)	**65,302,059**
Expenses				
Salaries, wages and fringe benefits	36,548,707	-	-	**36,548,707**
Supplies	6,420,917	-	-	**6,420,917**
Physician fees	3,834,940	-	-	**3,834,940**
Other	9,929,137	172,452	(10,000)	**10,091,589**
Medicaid enhancement tax	2,453,191	-	-	**2,453,191**
Depreciation and amortization	4,732,129	21,752	-	**4,753,881**
Interest	984,914	-	-	**984,914**
Total expenses	64,903,935	194,204	(10,000)	**65,088,139**
Operating income	53,066	160,854	-	**213,920**
Nonoperating gains (losses)				
Contributions	278,454	-	-	**278,454**
Development costs	(173,627)	-	-	**(173,627)**
Nonoperating investment income	3,886,039	-	-	**3,886,039**
Change in value of interest rate swap	(1,354,905)	-	-	**(1,354,905)**
Affiliation costs	(595,187)	-	-	**(595,187)**
Nonoperating gains, net	2,040,774	-	-	**2,040,774**
Excess of revenues and gains over expenses	2,093,840	160,854	-	**2,254,694**
Net assets released from restrictions for capital acquisitions	3,500	-	-	**3,500**
Net unrealized losses on investments	(3,132,760)	-	-	**(3,132,760)**
(Decrease) increase in net assets without donor restrictions	$ (1,035,420)	$ 160,854	$ -	**$ (874,566)**

Attachment 9

Rural Workgroup Summary Report

Rural WorkGroup - Combination Agreement

Quantify Value of Existing D-HH or GOH Relationship

SECTION 1 - COST SAVINGS OPPORTUNITIES COMPARING PRE-AFFILIATION TO POST- AFFILIATION

	Alice Peck Day	Cheshire	Huggins	Monadnock	Mt. Ascutney	New London	VNH	Total Savings
1. Shared Administrative Services (annual savings)								
debt re-finance			$300,000					**$400,000**
professional liability consolidation	$75,000				$60,000	$100,000	$8,000	**$243,000**
access to added capital saved on interest/loan					$150,000			**$150,000**
"other insurance"								**$0**
audit fees	$40,000	$46,000				$50,000		**$136,000**
annual $ savings from shared/supportive legal services		$120,000					$50,000	**$170,000**
annual $ savings from shared HR support					$25,000			**$25,000**
3. Group purchase entity/participation (annual savings)								
NEAH supplies	$73,242	$179,516		$63,129	$47,178	$49,662		**$412,727**
NEAH pharmacy								**$0**
Mckesson savings	$17,138	$336,392		$520,233	$30,006	$38,735		**$942,504**
Vizient/NPC savings	$6,515	$568,429		$182,038	$103,054	$58,552		**$918,588**
NEAH employee benefit group purchase								**$0**
Benefit Admin				$10,994	$7,099	$8,392		**$26,485**
TPA savings		$79,477		$46,575	$20,613	$24,398		**$171,063**
Dental Admin savings		$15,265		$8,777	$5,868	$7,889		**$37,799**
Life and Disability savings				$60,000	$36,101	$10,519		**$106,620**
Wellness vendor savings (Ebix)				$11,520	$6,298	$7,454		**$25,272**
PBM savings (OPTUM via D-H)		$261,009		$80,000	$71,515	$107,024		**$519,548**
stop loss savings (VOYA)		$558,417		$225,000	$134,890	$178,477		**$1,096,784**
NEAH other group purchase items (Medline)	$2,632	$3,020		$701	$867	$657		**$7,876**
defined benefit contribution					$71,377			**$71,377**
defined pension plan					$31,022			**$31,022**
4. Cost reductions from consolidation of services (annual savings)								
consolidated reference lab services				$200,000		$233,398		**$433,398**
reduced LOCUM dependency			$40,000					**$40,000**
5. Other notable areas of annual cost savings								
ITS Expense Savings		$1,479,000						**$1,479,000**
Total Savings	$214,527	$3,646,525	$340,000	$1,408,967	$800,888	$875,156	$58,000	**$7,334,063**

Total Investments by D-HH in Information Tech - Completed

EPIC Conversion	$7,200,000	$14,000,000		
Enterprise Resource Project	$1,400,000	$1,400,000		
			D-HH Investment Made -Total	**$24,000,000**

Total Investments by D-HH in Information Tech - Planned

(planned investments for current fiscal year and future fiscal year)

EPIC Conversion	$8,000,000	$8,000,000		
Enterprise Resource Project	$2,000,000	$2,000,000		
			D-HH Investment Planned - Total	**$20,000,000**

Attachment 10

CMCHS Best Practices Letter

BAKER NEWMAN NOYES

Baker Newman & Noyes LLC
MAINE | MASSACHUSETTS | NEW HAMPSHIRE
800.244.7444 | www.bnncpa.com

To Management and the Board of Trustees
CMC Healthcare System, Inc.

This letter includes comments and suggestions with respect to matters that came to our attention in connection with our audit of the consolidated financial statements of CMC Healthcare System, Inc. (the System) as of and for the year ended September 30, 2019. These items are not deemed significant control deficiencies but rather are offered as constructive suggestions to be considered part of the ongoing process of modifying and further strengthening the System's practices and procedures.

Timely Review of Account Reconciliations

Due to the general ledger conversion in fiscal year 2019, there were certain delays noted in the review and approval of various account reconciliations for a period of time after the conversion. While it appears this was back on an appropriate timeline by the end of the fiscal year, it is an important and fundamental control over account integrity to ensure that reconciliations are timely reviewed throughout the year.

Management's Response

Management acknowledges the importance of timely reconciliations to ensure the integrity of financial reporting. With the ERP conversion going live in sync with the 2018 fiscal year-end, formal reconciliations and related documentation lagged due to resource constraints. The finance department has made a concerted effort to be more timely and will continue to do so going forward.

Accounts Receivable

Due to the EMR system conversion in fiscal year 2019, the System experienced significant delays in billings in the last quarter of the fiscal year. This led to substantial increases in outstanding accounts receivable at September 30, 2019, and had a detrimental impact on the System's cash flow. While management is actively monitoring accounts receivable balances and has adequate reserves in place, we want to stress the importance of continuing to monitor the timely billing and collection of patient accounts, as well as the age of any outstanding balances. Month-end account reconciliations should continue to be scrutinized, and the System may benefit from offering additional training to employees on the new EMR system.

Management's Response

The Revenue Cycle team is actively engaged in assessing our accounts receivable position and action planning to move back to current. Efforts have included additional team resources, as well as outsourced resources, to help with the backlog from the go-live billing hold. This effort is cross-functional, including robust support from consultants, IT vendors and the System's internal IT department, to address system issues and additional functionality that will facilitate quicker processing. We will continue to monitor performance, measured by key performance indicators, to improve our current lag. The System has seen improvements week over week and expects a full recovery in the coming months.

Items Received Not Invoiced

The System received certain goods and services at September 30, 2019 that had not yet been invoiced by the vendor at September 30, 2019. Such items were recorded within the general ledger as 'received not invoiced' (RNI). When the related invoice is received, RNI is relieved. In evaluating the RNI account during the audit and discussing procedures with management, we noted that management has had some difficulties in fully reconciling this account since the System's general ledger conversion, and a full detailed reconciliation was not performed at September 30, 2019. Management does monitor the balance at a high level for reasonableness, however, we recommend that management fully reconcile this account on a regular basis during the year.

Management's Response

CMC, via GraniteOne, has engaged our EMR consultant to develop the necessary reports from Oracle in order to reconcile this balance. This will be made a priority in fiscal year 2020 to ensure the account is reconciled.

* * * * * * * * * *

The System's written responses to the comments identified in our audit have not been subjected to the auditing procedures applied in the audit of the consolidated financial statements and, accordingly, we express no opinion on them.

This letter is intended solely for the information and use of management, the Board of Trustees, and others within the System, and is not intended to be and should not be used by anyone other than these specified parties. We appreciate serving the System and would be happy to assist you in addressing and implementing any of the suggestions in this letter.

Baker Newman & Noyes LLC

Manchester, New Hampshire
February 4, 2020

Attachment 11

CMCHS No Material Weakness Letters; MCH and HH Auditor's Management Letters

BAKER NEWMAN NOYES

Baker Newman & Noyes LLC
MAINE | MASSACHUSETTS | NEW HAMPSHIRE
800.244.7444 | www.bnncpa.com

To the Board of Trustees,
CMC Healthcare System, Inc.

In planning and performing our audits of the consolidated financial statements of CMC Healthcare System, Inc. and the financial statements of Catholic Medical Center (collectively, the System) as of and for the year ended September 30, 2018, in accordance with auditing standards generally accepted in the United States of America, we considered the System's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the consolidated financial statements, but not for the purpose of expressing an opinion on the effectiveness of the System's internal control. Accordingly, we do not express an opinion on the effectiveness of the System's internal control.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A material weakness is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's consolidated financial statements will not be prevented, or detected and corrected, on a timely basis.

Our consideration of internal control was for the limited purpose described in the first paragraph and was not designed to identify all deficiencies in internal control that might be material weaknesses. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

This communication is intended solely for the information and use of management, the Board of Trustees, others within the System and the Medicare Administrative Contractor (MAC) and is not intended to be, and should not be, used by anyone other than these specified parties.

Baker Newman & Noyes LLC

Manchester, New Hampshire
February 12, 2019

BAKER NEWMAN NOYES

Baker Newman & Noyes LLC
MAINE | MASSACHUSETTS | NEW HAMPSHIRE
800.244.7444 | www.bnncpa.com

To the Board of Trustees,
CMC Healthcare System, Inc.

In planning and performing our audits of the consolidated financial statements of CMC Healthcare System, Inc. and the financial statements of Catholic Medical Center (collectively, the System) as of and for the year ended September 30, 2019, in accordance with auditing standards generally accepted in the United States of America, we considered the System's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the consolidated financial statements, but not for the purpose of expressing an opinion on the effectiveness of the System's internal control. Accordingly, we do not express an opinion on the effectiveness of the System's internal control.

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This communication is intended solely for the information and use of management, the Board of Trustees, others within the System and the Medicare Administrative Contractor (MAC) and is not intended to be, and should not be, used by anyone other than these specified parties.

Baker Newman & Noyes LLC

Manchester, New Hampshire
February 4, 2020

The Board of Trustees
Huggins Hospital and Subsidiary

We have audited the consolidated financial statements of Huggins Hospital (the Hospital) for the year ended September 30, 2019, and have issued our report thereon dated February 3, 2020. Professional standards require that we communicate to you the following information related to our audit.

Our Responsibility under U.S. Generally Accepted Auditing Standards

As stated in our engagement letter dated June 24, 2019, our responsibility, as described by professional standards, is to express an opinion about whether the consolidated financial statements prepared by management with your oversight are fairly presented, in all material respects, in conformity with U.S. generally accepted accounting principles. Our audit of the consolidated financial statements does not relieve you or management of your responsibilities.

Supplementary Information to the Audited Consolidated Financial Statements

Our responsibility for the supplementary information accompanying the consolidated financial statements, as described by professional standards, is to evaluate the presentation of the supplementary information in relation to the consolidated financial statements as a whole and to report on whether the supplementary information is fairly stated, in all material respects, in relation to the consolidated financial statements as a whole.

With respect to the supplementary information accompanying the consolidated financial statements, we made certain inquiries of management and evaluated the form, content, and methods of preparing the information to determine that the information complies with U.S. generally accepted accounting principles, the method of preparing it has not changed from the prior period, and the information is appropriate and complete in relation to our audit of the consolidated financial statements. We compared and reconciled the supplementary information to the underlying accounting records used to prepare the consolidated financial statements or to the consolidated financial statements themselves.

Significant Audit Findings

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by the Hospital are described in Note 1 to the consolidated financial statements.

Effective for the year ended September 30, 2019, the Hospital adopted and retrospectively applied the provisions of Financial Accounting Standards Board (FASB) Accounting Standards Update (ASU) No. 2016-14, *Presentation of Financial Statements of Not-for-Profit Entities* (Topic 958). The ASU marks the completion of the first phase of a larger project aimed at improving not-for-profit financial reporting. Under the ASU, net asset reporting is streamlined and clarified. The previous three-category classification of net assets was replaced with a simplified model that combines temporarily restricted and permanently restricted into a single category called “net assets with donor restrictions.” The guidance on accounting for the lapsing of restrictions on gifts to acquire property and equipment has also been simplified and clarified. New disclosures highlight restrictions on the use of resources that make otherwise liquid assets unavailable for meeting near-term financial requirements. The ASU also imposes several new requirements related to reporting expenses. New or revised disclosures in the

financial statements are: Note 1 – Summary of Significant Accounting Policies (Basis of Presentation), Note 4 – Availability and Liquidity of Financial Assets, Note 12 – Net Assets with Donor Restrictions, and Note 15 – Functional Expenses.

No other new accounting policies were adopted and the application of existing policies was not otherwise changed during 2019. We noted no transactions entered into by the Hospital during the year for which there is a lack of authoritative guidance or consensus. All significant transactions have been recognized in the consolidated financial statements in the proper period. The financial statement disclosures are neutral, consistent and clear.

Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users. The most sensitive disclosures affecting the consolidated financial statements are:

- Organization footnote – GraniteOne Health and Dartmouth-Hitchcock Health combination agreement
- Note 2 – Net patient service revenue
- Note 4 – Availability and liquidity of financial assets
- Note 7 – Fair value measurements as they relate to investments
- Note 11 – Commitments and contingencies

Management Judgments and Accounting Estimates

Accounting estimates are an integral part of the consolidated financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the consolidated financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimates affecting the consolidated financial statements were:

- Management's estimate of the allowance for contractual adjustments and allowance for uncollectible accounts. These estimates are based on historical reimbursement percentages in relation to gross charges for services and a review of outstanding balances aged by financial class. Management also reviews troubled, aged accounts to determine collection potential.

- Management's estimates for amounts due to and from third-party payors. Adjustments to net patient service revenue are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. The current process involves calculating estimates of cost reports to be filed and disproportionate share hospital payment settlements based on current year data and current regulations. Estimates of prior year amounts are updated as additional information (including filed cost reports, interim settlements, and audits) becomes available.

- Management's estimate of fair value measurements. This is based on the established fair value hierarchy from FASB Accounting Standards Topic 820, *Fair Value Measurement*. This requires management to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. Management's process is described in Note 7 to the financial statements.

- Management's estimate of depreciation. This is based on the straight-line method applied to estimated useful lives established by the American Hospital Association, intended to amortize the cost of the assets over their estimated useful lives.

We have evaluated the key factors and assumptions used to develop these estimates to satisfy ourselves as to their reasonableness in forming our opinion that the financial statements taken as a whole are fairly stated in all material respects.

Difficulties Encountered in Performing the Audit

We encountered no significant difficulties in dealing with management in performing and completing our audit.

Corrected and Uncorrected Misstatements

Professional standards require us to accumulate all known and likely misstatements identified during the audit, other than those that are trivial, and communicate them to the appropriate level of management. An audit adjustment is defined as a proposed correction of the financial statements that, in our judgment, may not have been detected except through our auditing procedures. There were no audit adjustments as defined herein.

A passed audit adjustment is an adjustment that is not proposed as a current year audit adjustment because the dollar amount of the adjustment is not considered material to the financial statements. There were no passed audit adjustments.

Disagreements with Management

For purposes of this letter, professional standards define a disagreement with management as a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the consolidated financial statements or the auditor's report. We are pleased to report that no such disagreements arose during the course of our audit.

Management Representations

We have requested certain representations from management that are included in the management representation letter dated as of the date of this letter.

Management Consultations with Other Independent Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to the Hospital's consolidated financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Other Audit Findings or Issues

We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as the Hospital's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

INTERNAL CONTROL MATTERS

In planning and performing our audit of the Hospital's consolidated financial statements as of and for the year ended September 30, 2019, in accordance with U.S. generally accepted auditing standards, we considered the Hospital's internal control over financial reporting (internal control) as a basis for designing our auditing procedures for the purpose of expressing our opinion on the consolidated financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Hospital's internal control. Accordingly, we do not express an opinion on the effectiveness of the Hospital's internal control.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A material weakness is a deficiency, or combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the Hospital's financial statements will not be prevented, or detected and corrected, on a timely basis.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Control Deficiencies

Manual Overrides

During our documentation of the accounts payable (AP) process, it was identified that employees who have access to the AP module have access in the system to perform manual overrides of approvals. In order to prevent undesirable overrides, we recommend management works with the Information Technology department and Oracle to build a report that would show all manual overrides. Additionally the Accounting Manager should document review of the report on a monthly basis and support should be obtained for any manual overrides indicated on the report.

Management's Response:

The Hospital has adopted a report that was provided to Catholic Medical Center (CMC) by our third party consultant. For 2020, we have reviewed the report for any invoices that have been force approved to determine if the invoices were legitimate. Huggins Controller and VP of Finance will document their review of these invoices to ensure accuracy in processing. When applicable, we will obtain manual management approval in the event immediate payment is required and system or time constraints prevent immediate payment from occurring.

Hold Status Vouchers

During our documentation of the accounts payable (AP) process, it was identified that the AP clerk has access to clear vouchers from a hold status. Once the vouchers are cleared from the hold status, they are automatically approved for payment. The AP clerk then has the ability to pay the vouchers with this approval. We recommend management remove the AP clerk's access to release vouchers from the hold status or have a report built that shows all vouchers that have been cleared from the hold status and the report should be reviewed by the Accounting Manager on a monthly basis.

Management's Response:

The Hospital has engaged both CMC and Apps Associates (third party Oracle support group) to have a report created that allows us to see the user that was responsible for Holds clearing. Any line that was cleared by anyone that does not work within the Materials Management Department will be reviewed by the Controller to determine validity and justification for the clearing of the hold. Members of the Finance team are unlikely to clear holds, but may need to in order to process payment in immediate need.

Advisory Comments

As part of our audit process, we gained an understanding of the general information technology (IT) controls of the Hospital. Our work did not involve an in-depth assessment of the Hospital's conversion to Oracle. As part of our inquiries, we did identify the following recommendations to further enhance the Hospital's IT controls:

- Testing of Oracle Software Updates

  When relying on CMC's testing of less significant Oracle software updates, the Hospital should still document such review has been performed.

- Service Organization Control (SOC) Reports

  While the Hospital does obtain and review the SOC reports of its IT system vendors, we recommend documenting the review and documenting how Huggins has implemented the Complementary User Entity Controls included in the SOC reports. These are intended to be performed in conjunction with the related controls at the service organization (vendor). In addition, three of the four IT vendor SOC reports had qualified opinions. The Hospital should evaluate the impact of the qualifications on its internal control structure and any modifications that should be made internally to compensate for such risks.

INDUSTRY-RELATED COMMENT

Revenue from Contracts with Customers

The FASB issued ASU No. 2014-09, *Revenue from Contracts with Customers*, in 2014 to replace the current plethora of industry-specific rules with a broad, principles-based framework for recognizing and measuring revenue. The primary principle of the standard is that an entity should recognize revenue in an amount that reflects the consideration to which the entity expects to be entitled to in exchange for goods or services provided to customers (i.e., patients). Entities must follow the following five-step process to achieve the primary principle under the new standard:

1. Identify the contract with the customer (patient):

   - For hospitals and clinics, a legally enforceable contract can be written, oral, or implied based on the entity's customary businesses practices. Written or oral contracts can include:

     - Signed patient responsibility forms
     - Consent of service forms
     - Patient scheduled appointments (online, in person, telephone, etc.)

- Certain health care entities are required by law or regulation to treat emergency conditions (for example, through a hospital's emergency department) and often provide services to uninsured or underinsured patients regardless of the patient's ability to pay. Some not-for-profit health care entities are tax-exempt under IRC Section 501(c)(3) as charitable organizations and, therefore, have certain requirements to maintain their tax-exempt status, charitable mission, or both. These entities may take the position, based on their legal and charitable requirements, that an implied contract has been established with its patients. Therefore, entities may consider the involvement of legal counsel in making a determination of when they have a legally enforceable contract with a patient.

2. Identify separate performance obligations in the contract (if applicable).

3. Determine the transaction price:

    - For hospitals and clinics, the transaction price is ultimately the amount they will record as net patient service revenue for services provided to a patient or portfolio of patients. The transaction price includes the effects of variable consideration (explicit or implicit) and the consideration of other constraints.

    - Explicit price concessions are commonly negotiated contractual rates with third-party payors and discounts offered to patients with no insurance based on the entity's policy (self-pay discounts).

    - Under the new revenue recognition standard, the consideration of implicit price concessions will be required. Some scenarios entities may consider when determining if they intend to provide an implicit price concession are when:

        - The entity's customary business practice is to not perform a credit assessment prior to providing services (i.e., the entity is required by law to provide the services or its mission is to provide medically necessary or emergency services prior to assessing the patient's ability to pay).

        - The entity continues to provide services to a patient, or patient class, even when their historical experience shows that it is not probable it will collect substantially all of the discounted charges.

    - Even after considering variable price concessions, entities should incorporate any other constraints that may exist related to the patient's (or patients in the patient class) ability to pay that may result in a significant revenue reversal at some point in the future.

4. Allocate the transaction price to the separate performance obligations in the contract (if applicable):

    - Under the revenue recognition standard the allocation of the transaction price will likely be no different than how gross revenues are reflected today for the services provided to patients.

5. Recognize revenue when the entity satisfies the performance obligation:

    - The timing of when revenue is recorded today is not expected to change significantly under the revenue recognition standard.

Entities will be required to adopt the revenue recognition standard retrospectively to each prior period presented, which includes optional practical expedients, or retrospectively using the cumulative effect method recognized at the date of initial application of the new standard. Public business entities, certain not-for-profit entities, and certain employee benefit plans will apply the guidance to annual reporting periods beginning after December 15, 2017, and all other entities, including the Hospital, will apply the guidance to annual reporting periods beginning after December 15, 2018 (fiscal year ending September 30, 2020 for the Hospital).

Accounting Guidance for Contributions Received and Contributions Made

In July 2018, the FASB issued ASU No. 2018-08, *Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made*, to clarify and improve the accounting guidance for contributions received and contributions made. The amendments in this ASU assist entities in (1) evaluating whether transactions should be accounted for as contributions (nonreciprocal transactions) within the scope of Accounting Standards Codification Topic No. 958, *Not-for-Profit Entities*, or as exchange (reciprocal) transactions subject to other guidance, and (2) distinguishing between conditional contributions and unconditional contributions.

Many stakeholders have noted difficulty in characterizing grants and similar contracts as either exchange transactions or contributions and in distinguishing between conditional contributions and unconditional contributions when applying the guidance in Subtopic 958-605, *Not-for-Profit Entities – Revenue Recognition*.

Distinguishing between contributions and exchange transactions determines which guidance is applied. For contributions, an entity should follow the guidance in Subtopic 958-605, whereas for exchange transactions, an entity should follow other guidance. Thus, the accounting may be different depending on the guidance applied. Diversity in practice occurs for grants and other similar contracts from various types of organizations, but it is most prevalent for government grants and contracts.

In addition, once a transaction is deemed to be a contribution, organizations have noted that it can be difficult in practice to distinguish between conditional contributions and unconditional contributions. Differences in these conclusions can affect the timing of revenue recognized.

The amendments in this ASU clarify and improve current guidance. Entities should apply the amendments in this ASU on contributions received to annual periods beginning after December 15, 2018.

FASB ASU No. 2016-02, *Leases (Topic 842)*

On February 25, 2016, FASB issued ASU No. 2016-02 to address changes to the accounting for leases by lessees and lessors. Under the new standard, lessees would be required to record the right-to-use leased assets and liabilities for all leases with terms exceeding 12 months (similar to the accounting for capital leases under current accounting rules).

The right-to-use asset is initially measured at the present value of the lease payments plus initial direct costs. For purposes of these rules, the lease term includes renewal periods only if the lessee is reasonably certain to exercise an option to extend the lease or not to exercise an option to terminate the lease.

Expense related to the lease would be recorded as follows:

- For **finance (capital) leases**, interest on the lease should be recognized separately from the amortization of the leased asset using the interest method. Repayments of the principal portion of the lease liability will be classified within financing activities on the statement of cash flows and payments of interest on the lease liability and variable lease payments within the operating activities in the statement of cash flows.

- For **operating leases**, the cost of the lease plus initial direct costs is allocated over the lease term on a straight-line basis and all cash payments are recorded within operating activities on the statement of cash flows.

The current specialized accounting rules for leveraged leases and sale-leasebacks no longer apply.

This ASU is effective for most not-for-profit entities for periods beginning after December 15, 2020 (FY 2022 for the Hospital).

Recognition and Measurement of Financial Assets and Financial Liabilities

In January 2016, FASB issued ASU No. 2016-01, *Recognition and Measurement of Financial Assets and Financial Liabilities*. The main provisions require equity investments to be measured at fair value with changes in fair value recognized in net income. Equity investments that do not have readily determinable fair values can be carried at cost less impairment. The ASU will be effective for the Hospital beginning October 1, 2019.

* * * * * * * * * * *

Management's written responses have not been subjected to the auditing procedures applied in the audit of the consolidated financial statements and, accordingly, we express no opinion on them.

This communication is intended solely for the information and use of Board of Trustees and management of Huggins Hospital and Subsidiary and is not intended to be, and should not be, used by anyone other than these specified parties.

Berry Dunn McNeil & Parker, LLC

Portland, Maine
February 3, 2020

Attachment 12

D-H Endowment Fund Policy

Dartmouth-Hitchcock
1 Medical Center Drive
Lebanon, NH 03756-0001

To: Tina Naimie, Vice President, Corporate Finance
From: Michael Waters, Director, Assistant Treasurer
Subject: Annual Endowment Apportionment of Expenditures or Accumulation of Endowment Funds Recommendation for FY2020
Date: March 11, 2019

Per our Endowment Funds Administration Policy, Section IV-B "Apportion for Expenditures or Accumulation of Endowment Funds", D-H may appropriate for expenditure or accumulate so much of an endowment fund as the institution determines is prudent for the uses, benefits, purposes, and duration for which the endowment fund is established. Unless stated otherwise in the gift instrument, the assets in the endowment fund are donor-restricted assets until appropriated for expenditure by the institution. In making the determination to appropriate or accumulate, D-H shall act in good faith, with the care that an ordinarily prudent person in a like position would exercise under similar circumstances, and shall consider the following factors:

1. The duration and preservation of the endowment fund;
2. The purposes of D-H and the endowment fund;
3. General economic conditions including the possible effect of inflation and deflation;
4. The expected total return from income and the appreciation of investments;
5. Other resources of D-H; and
6. The investment policy of the D-H.

Furthermore, as recommended by the D-H Finance Committee, the apportionment rate should also accomplish three objectives:

- Generation of an income level sufficient to meet the programmatic needs for which our endowment funds were established;
- Preservation of the purchasing power of the endowment funds at a level equal to inflation; and
- Achievement of real growth in the endowment to support future needs.

In addition D-H acknowledges that the State of New Hampshire considers an appropriation for expenditure in any year of any amount greater than 7% of the fair market value of an endowment fund, calculated on the basis of fair market value determined at least quarterly and averaged over a period of not less than 3 years immediately preceding the year in which the appropriation for expenditure was made, to create a rebuttable presumption of imprudence.

Therefore, the amount of the annual apportionment for expenditure or accumulation of endowment funds in accordance with the gift instrument will be established and approved annually by the Chief Financial Officer, under the guidelines established in the policy approved by the D-H Finance Committee and Board of Trustees. Such amount will be computed based upon a percentage, not to exceed 7%, which will be applied to the immediately preceding three-year fair market value of the endowment assets.

ANALYSIS

Component	Value	Source
Expected Investment Return	*6.50%*	Annual Analysis Performed by D-H Investment Advisor, NEPC
Less: Provision for Maintaining Purchasing Power	*1.50%*	5 Year Average Inflation, as Reported by U.S. Department of Labor Consumer Price Index (CPI)
Less: Provision for Conservatism/Endowment Growth	*1.0%*	Conservatism factor consistent with overall history
Apportionment Rate (Total)	***4.00%***	(Rounded to nearest quarter point)

RECOMMENDATION

Based on the analysis above, it is hereby proposed that D-H establish a 4.00% apportionment rate for the 2020 Fiscal Year to be applied to the three year rolling averages of approximately $39 million of donor restricted endowment fund balances at December 31, 2018.

Dartmouth-Hitchcock

Policy Title:	Endowment Fund Policy	Policy ID:	5648
Keywords	endowment funds, endowment spending		

I. Purpose of Policy

The purpose of this policy is establish Dartmouth-Hitchcock's (D-H's) standard of conduct for managing and investing donor-restricted endowment funds and/or funds designated by the Board of Trustees to function as endowments, appropriating expenditure thresholds, delegating management and investment functions, and releasing or modifying restrictions.

II. Policy Scope

The policy applies to all Dartmouth-Hitchcock departments and locations who maintain and use institutional endowment funds. This policy applies to institutional funds existing on or established after July 1, 2008. As applied to institutional funds existing on July 11, 2008, this policy governs only decisions made or actions taken on or after that date.

III. Definitions

Dartmouth-Hitchcock (D-H): The affiliation of the Dartmouth-Hitchcock Clinic (D-HC) and Mary Hitchcock Memorial Hospital (MHMH) entities.

Charitable purpose: The relief of poverty, the advancement of education or religion, the promotion of health, the promotion of a governmental purpose, or any other purpose the achievement of which is beneficial to the community.

Endowment fund: An institutional fund or part thereof that, under the terms of a gift Instrument, is not wholly expendable by the institution on a current basis. The term does not include assets that D-H designates as an endowment fund for its own use. More specifically, this policy pertains to funds D-H classifies as Permanently Restricted Funds. This policy does not pertain to funds D-H classifies as Board Designated or Temporarily Restricted.

Gift instrument: A record or records, including an institutional solicitation, under which property is granted to, transferred to, or held by an institution as an institutional fund.

Institution:

i. A person, other than an individual, organized and operated exclusively for charitable purposes.

ii. A government or governmental subdivision, agency or instrumentality, to the extent that it holds funds exclusively for a charitable purpose.

iii. A trust that had both charitable and non-charitable interests, after all non-charitable interests have terminated.

Institution fund: A fund held by D-H exclusively for charitable purposes. The term does not include:

i. Program-related assets;

ii. A fund held for an institution by a trustee that is not an institution;

iii. A fund in which a beneficiary that is not an institution has an interest, other than an interest that could arise upon violation or failure of the purposes of the fund; or

iv. A fund held by a town or other municipality under RSA 31:19, RSA 202-A:23, or a fund created by a town or other municipality under RSA 31:19-a.

Person: An individual, corporation, business trust, estate, trust, partnership, Limited Liability Company, association, joint venture, public corporation, government or governmental subdivision, agency or instrumentality, or any other legal or commercial entity.

Program related asset: An asset held by an institution primarily to accomplish a charitable purpose of the institution and not primarily for investment.

Record: Information that is inscribed on a tangible medium or that is stored in an electronic or other medium and is retrievable in perceivable form.

IV. Policy Statement

D-H will comply with the Uniform Prudent Management of Institutional Funds Act of 2007 (the Act) as promulgated by New Hampshire House Bill 1382 (H81382):

A. Managing and Investing Institutional Funds (HB 1382 (292-B:3))

i. Subject to the intent of a donor expressed in a gift instrument, D-H, in managing and investing an institutional fund, shall consider the charitable purposes of the institution and the purposes of the institutional fund.

ii. In addition to complying with the duty of loyalty imposed by law, each D-H representative responsible for managing and investing an institutional fund shall manage and invest the fund in good faith and with the care an ordinary prudent person in a like position would exercise under similar circumstances.

iii. In managing and investing an institutional fund, D-H:
   a. May incur only costs that are appropriate and reasonable in relation to the assets; and
   b. Shall make a reasonable effort to verify facts relevant to the management and investment of the fund.

iv. D-H may pool 2 or more institutional funds for purposes of management and investment.

v. Except as otherwise provided by a gift instrument, the following rules apply:

a) In managing and investing an institutional funds, the following factors, if relevant, shall be considered:

1. General economic conditions.
2. The possible effect of inflation or deflation.
3. The expected tax consequences, if any, of investment decisions or strategies.
4. The role that each investment or course of action plays within the overall investment portfolio of the fund.
5. The expected total return from income and the appreciation of investments.
6. Other resources of D-H.
7. The needs of D-H and the fund to make distributions and to preserve capital.
8. An asset's special relationship or special value, if any, to the charitable purposes of D-H.

b) Management and investment decisions about an individual asset must be made not in isolation but rather in the context of the institutional fund's portfolio of investments as a whole and as a part of an overall investment strategy having risk and return objectives reasonably suited to the fund and to the institution.

c) Except as otherwise provided by law, D-H may invest in any kind of property or type of investment consistent with these rules.

d) D-H shall diversify the investments of an institutional fund unless the institution reasonably determines that, because of special circumstances, the purposes of the fund are better served without diversification.

e) Within a reasonable time after receiving property, D-H shall make and carry out decisions concerning the retention or disposition of the property or to rebalance the portfolio in order to bring the institutional fund into compliance with the purposes, terms, and distribution requirements of the institution as necessary to meet other circumstances of the institution and the requirements of HB1382.

f) Any D-H staff that has special skills or expertise, or is selected in reliance upon the staff's representation that the staff has special skill or expertise, has a duty to use those skills or that expertise in managing and investing institutional funds.

B. Appropriation for Expenditures or Accumulation of Endowment Funds (HB 1382 (292-B:4))

i. Subject to the intent of a donor expressed in a gift instrument, D-H, may appropriate for expenditure or accumulate so much of an endowment fund as the institution determines is prudent for the uses, benefits, purposes, and duration for which the endowment fund is established. Unless stated otherwise in the gift instrument, the assets in the endowment fund are donor-restricted assets until appropriated for expenditure by the institution. In making the determination to appropriate or accumulate, D-H shall act in good faith, with the care that an ordinarily prudent person in a like position would exercise under similar circumstances, and shall consider the following factors:

1. The duration and preservation of the endowment fund;
2. The purposes of D-H and the endowment fund;
3. General economic conditions;
4. The possible effect of inflation and deflation;
5. The expected total return from income and the appreciation of investments;

6. Other resources of D-H; and
7. The investment policy of the D-H.

ii. To limit the authority to appropriate for expenditure or accumulate under paragraph "i," a gift instrument must specifically state the limitation.

iii. Terms in a gift instrument designating a gift as an endowment, or a direction or authorization in the gift instrument to use only "income," "interest," "dividends," or "rents, issues or profits," or "to preserve the principal intact" or words of similar import:

a. Create an endowment fund of permanent duration unless other language in the gift instrument limits the duration or purpose of the fund; and
b. Do not otherwise limit the authority to appropriate for expenditure or accumulate under paragraph "i."

iv. D-H shall notify the Attorney General upon its adoption of the provisions of RSA 292-B for any new endowment fund received after July 1, 2008 with a market value of $2,000,000.

v. If D-H has endowment funds with an aggregate value of less than $2,000,000, D-H shall notify the Attorney General at least 60 days prior to an appropriation for expenditure of an amount that would cause the value of the institution's endowment funds to fall below the aggregate historic dollar value of D-H's endowment funds. During the 60-day period the Attorney General may require the institution to obtain court approval for the proposed expenditures.

a) For purposes of this section, "historic dollar value" means the aggregate value in dollars of:
1. Each endowment fund at the time it became an endowment fund.
2. Each subsequent donation to the fund at the time the donation is made.
3. Each accumulation made pursuant to a direction in the applicable gift instrument at the time the accumulation is added to the fund.
4. D-H's determination of historic dollar value made in good faith is conclusive.

vi. The appropriation for expenditure in any year of any amount greater than 7% of the fair market value of an endowment fund, calculated on the basis of fair market value determined at least quarterly and averaged over a period of not less than 3 years immediately preceding the year in which the appropriation for expenditure was made, creates a rebuttable presumption of imprudence. For an endowment fund in existence for fewer than 3 years, the fair market value of the endowment fund shall be calculated for the period of time the endowment fund has been in existence.

C. Delegation of Management and Investment Functions (HB 1382 (292-B:S))

i. Subject to any specific limitation set forth in a gift instrument or in law other than this chapters, D-H may delegate to an external agent the management and investment of an institutional fund to the extent that D-H shall act in good faith, and with the care that an ordinarily prudent person in a like position would exercise under similar circumstances, in:
a. Selecting an agent.
b. Establishing the scope and terms of the delegation, consistent with the purposes of the institution and the institutional fund.

c. Periodically reviewing the agent's actions in order to monitor the agent's performance and compliance with the scope and terms of the delegation.

ii. In performing a delegated function, an agent owes a duty to the institution to exercise reasonable care to comply with the scope and terms of the delegation.

iii. If D-H complies with paragraph "i," D-H is not liable for the decisions or actions of an agent to which the function was delegated.

iv. By accepting delegation of a management or investment function from an institution that is subject to the laws of this state, an agent submits to the jurisdiction of the courts of this state in all proceedings arising from or related to the delegation or the performance of the delegated function.

v. D-H may delegate the management and investment functions to its committees, officers, or employees as authorized by other laws of the State of New Hampshire.

D. Release or Modification of Restrictions (HB 1382 (292-B:6))

i. If the donor consents in a record, D-H may release or modify, in whole or in part, a restriction contained in a gift instrument on the management, investment, or purpose of an institutional fund. A release or modification may not allow a fund to be used for a purpose other than the charitable purpose of D-H.

ii. The court, upon application from D-H, may modify a restriction contained in a gift instrument regarding the management or investment of an institutional fund if the restriction has become impracticable or wasteful, if it impairs the management or investment of the fund, or if, because of circumstances not anticipated by the donor, a modification of a restriction will further the purposes of the fund. D-H shall notify the Attorney General of the application, and the Attorney General must be given an opportunity to be heard.

iii. If D-H determines that a restriction contained in a gift instrument on the management, investment, or purpose of an institutional fund is unlawful, impracticable, impossible to achieve, or wasteful, D-H, 60 days after notification to the Attorney General, may release or modify the restriction, in whole or part, if:

a) The institutional fund subject to the restriction has a total value of less than $25,000,

b) More than 25 years have elapsed since the fund was established; and

c) D-H uses the property in a manner consistent with the charitable purposes expressed in the gift instrument.

V. References

New Hampshire House Bill 1382 (H81382)

Responsible Owner:	Corporate Finance	**Contact(s): email**	Bruce.A.Adams@Hitchcock.org Tina.E.Naimie@Hitchcock.org
Approved By:	Chief Officer - Finance; Office of Policy Support - Organizational Policies Only	**Version #**	1
Current Approval Date:	12/11/2017	**Old Document ID:**	
Date Policy to go into Effect:	12/11/2017		
Related Polices & Procedures:			
Related Job Aids:			

Attachment 13

NHAG Donor Restricted Funds (A) MCH and (B) HH

Monadnock Community Hospital
Permanently Restricted Reconciliation
9/30/94 - 9/30/19

	Permanently Restricted				Temporarily Restricted					Unrestricted			
Fiscal Year	Beginning Balance	Donations	Adoption of 116/117 & 124	Ending Balance	Cumulative Prior year appreciation	Adoption of 116/117 & 124	Fiscal Appreciation	Transfer (to) /from UR	tion	Prior year appreciation	Transfer (to) /from TR (spending policy)	Realized & Unrealized G/L	Ending Appreciation
09/30/1994	4,069,312		(1,564,385)	2,504,927	0	2,881,090		(393,518)	2,487,572		393,518		
09/30/1995	2,504,927			2,504,927	2,487,572		937,909	-	3,425,481		-		
09/30/1996	2,504,927			2,504,927	3,425,481		725,094	-	4,150,575		-		
09/30/1997	2,504,927			2,504,927	4,150,575		1,522,631	(127,347)	5,545,859		127,347		
09/30/1998	2,504,927			2,504,927	5,545,859		979,386	(79,417)	6,445,828		79,417		
09/30/1999	2,504,927			2,504,927	6,445,828		1,246,921	(88,258)	7,604,491		88,258		
09/30/2000	2,504,927			2,504,927	7,604,491		1,756,947	(88,589)	9,272,849		88,589		
09/30/2001	2,504,927			2,504,926	9,272,849		(1,446,173)	(93,112)	7,733,564		93,112		
09/30/2002	2,504,926	-		2,504,926	7,733,564		(1,244,631)	(439,511)	6,049,422		439,511		
09/30/2003	2,504,926	-		2,504,926	6,049,422		554,714	(438,036)	6,166,100		438,036		
09/30/2004	2,504,926	114,012		2,618,938	6,166,100		236,852	(423,000)	5,979,952		423,000		
09/30/2005	2,618,938	250,000		2,868,938	5,979,952		203,443	(6,183,395)	-		6,183,395		
09/30/2006	2,868,938	-		2,868,938	-		294,829	(294,829)	-		294,829		
09/30/2007	2,868,938	244,200		3,113,138	-		475,211	(475,211)	-		475,211		
09/30/2008	3,113,138	107,849		3,220,987	-		(443,269)		(443,269)				
09/30/2009	3,220,987	-		3,220,987	(443,269)		(10,734)	476,252	22,249	-	(476,252)	(116,688)	(592,940)
09/30/2010	3,220,987	517		3,221,505	22,249		-		22,249	(592,940)		224,550	(368,390)
09/30/2011	3,221,505	1,000,077		4,221,582	22,249		-		22,249	(368,390)		168,045	(200,345)
09/30/2012	4,221,582	-		4,221,582	22,249		508,482		530,731	(200,345)		200,345	-
09/30/2013	4,221,582	-		4,221,582	530,731		507,821		1,038,552	-			-
09/30/2014	4,221,582	-		4,221,582	1,038,552		555,276		1,593,828	-			-
09/30/2015	4,221,582	-		4,221,582	1,593,828		299,761		1,893,589	-			-
09/30/2016	4,221,582	-		4,221,582	1,893,589		374,528	-	2,268,117	-	-		-
09/30/2017	4,221,582	-		4,221,582	2,268,117		710,540	(239,648)	2,739,009	-	239,648		239,648
09/30/2018	4,221,582	-		4,221,582	2,739,009		1,025,629	(239,648)	3,524,990	239,648	239,648		479,296
09/30/2019	4,221,582	-		4,221,582	3,524,990		600,087	(268,104)	3,856,973	479,296	268,104		747,400
		Cost	Appreciation										
	Lord Trust	4,700,484	(8,272)	4,692,213									
	Wonders Trust	143,187	24,544	167,731									
			Total PR @ 9/30/19	**9,081,526**							**9,395,371**	**Actual Spending 1994 - 2019**	

A: 9/30/94 Beginning

B: restated as part of 1996 audit Note 10

C: C1+C2

D: 1994 Spending per AFS, note 10

	FN9	Rollforward	
PR donations & a	8,076,414	8,078,555	(2,141)
Trusts	4,862,084	4,859,944	2,140
	12,938,498	12,938,499	(1)

SCHEDULE 3.9.3.l(b)
HH PRE-AFFILIATION ASSETS

i. UNRESTRICTED ENDOWMENT

GL Acconn	Oracle Natural GL	GL Description	Financial Statements Updated	Current Financial category	Restrictions	12/31/2016	9/30/2017	9/30/2019
10000000	100905	TDBANKNORTH-CASH	110 Cash	110 Cash	Unrestricted	$ 6,747,428.89	$ 7,327,159.46	$ 1,148,184.06
10002000	100909	MERCHANT ACCT-CHARGE CARDS	110 Cash	110 Cash	Unrestricted	$ 600,881.77	$ 826,200.54	$ 184,683.75
10004000	100800	PETTY CASH-CASH	110 Cash	110 Cash	Unrestricted	$ 2,580.00	$ 2,580.00	$ 2,580.00
10014000		TDBANKNORTH BDF-CASH	110 Cash	110 Cash	Unrestricted	$ 993,041.86	$ 993,784.84	$ -
	100100	HUGGINS HOSPITAL OPERATING CIT X1381	110 Cash	110 Cash	Unrestricted	$ -	$ -	$ 4,117,306.13
	100103	HUGGINS HOSPITAL MERCHANT CIT X1438	110 Cash	110 Cash	Unrestricted	$ -	$ -	$ 1,289,674.64
	100104	HUGGINS HOSPITAL MM CIT X0000	110 Cash	110 Cash	Unrestricted	$ -	$ -	$ 1,998,747.95
	100108	HUGGINS HOSPITAL MM MVSB X0982	110 Cash	110 Cash	Unrestricted	$ -	$ -	$ 1,872,441.39
	100109	HUGGINS HOSPITAL CHK MVSB X0515	110 Cash	110 Cash	Unrestricted	$ -	$ -	$ 105.00
	100111	HH LEGACY CITIZENS MM X0481	110 Cash	110 Cash	Unrestricted	$ -	$ -	$ 1,310.13
10000008		CASH-2009 INTEREST	125 ALATU-Current		Bond Restricted	$ 242,672.95	$ -	$ -
10000009		DEBT SERVICE RESERVE FUND - 07	125 ALATU-Current		Bond Restricted	$ 149,231.45	$ -	$ -
10000010		2009 BOND PRINCIPAL	125 ALATU-Current		Bond Restricted	$ 64,030.05	$ -	$ -
10000100		TD BANK - MISCELLANEOUS FUNDS	125 ALATU-Current		Bond Restricted	$ 10,972.04	$ 11,507.31	$ -
10000004		CASH-DEBT SERVICE RES FUND 09	160 ALATU-Longterm		Bond Restricted	$ 1,210,313.54	$ 683.73	$ -
10053000	180110	BNY MELLON - FUNDED DEPRECIATI	160 ALATU-Longterm	180 Board Designated Investments	Unrestricted	$ 24,113,043.32	$ 30,526,383.86	$ 33,536,589.13
10054070	180111	COMMON FUND-BDF	160 ALATU-Longterm	180 Board Designated Investments	Unrestricted	$ 638,722.21	$ 649,870.84	$ 683,113.90
10030000	180100, 108101	OPERATING FUND CD'S	165 Investments Long Term	180 Board Designated Investments	Unrestricted	$ 1,038,725.49	$ 1,049,419.79	$ 1,076,870.58
10054000	180115	INVESTMENTS-EDF	165 Investments Long Term	180 Board Designated Investments	Unrestricted	$ 6,820,826.89	$ 7,517,556.56	$ 8,229,368.12
					Total Unrestricted	**$ 42,632,470.46**	**$ 48,905,146.93**	**$ 54,140,974.78**
10054010	180113	INVESTMENT IN BENEFICIAL TRUST		180 Board Designated Investments	Donor restricted	$ 6,435,200.50	$ 6,366,715.41	$ 6,053,686.83
10013000		TDBANKNORTH SPECIFIC PURPOSE			Donor restricted	$ 70,274.57	$ 87,219.78	$ -
10054030	180115	INVESTMENT -ENDOWMENT		180 Board Designated Investments	Donor restricted	$ 11,136,447.41	$ 11,911,465.11	$ 11,956,411.90
10054080	180112	PORCELAIN BIRD COLLECTION		180 Board Designated Investments	Donor restricted	$ 74,600.00	$ 74,600.00	$ 74,600.00
					Total Restricted	**$ 17,716,522.48**	**$ 18,440,000.30**	**$ 18,084,698.73**
					TOTAL NON-REAL ESTATE	**$ 60,348,992.94**	**$ 67,345,147.23**	**$ 72,225,673.51**

ii. NON-OPERATING REAL ESTATE

Property Location	Town	Map and Lot	Description of Location	Assessed Valuation 12/30/2016	9/30/2017	9/30/2019
		Sugar Hill/Huggins Senior Housing-Related Properties				
18-20 Vista Drive, Pine Hill Road	Wolfeboro	145-22	SHRC (Hughes 80 acres)	$ 869,700.00	$ 869,700.00	$ 869,700.00
Off Beach Pond Road	Wolfeboro	145-1-1	SHRC (Clough 40 acres) Ossipee land	$ 95,300.00	$ 95,300.00	$ 95,300.00
97 Route 28	Ossipee	133-27	of Rte 28 and 171	$ 61,800.00	$ 61,800.00	$ 61,800.00
			Total	**$ 1,026,800.00**	**$ 1,026,800.00**	**$ 1,026,800.00**
		Hospital Owned Property Unrelated to Operations				
8 Main Street	Alton	1672 -273	Alton Old Practice	$ 427,700.00	$ -	$ -
3 Water Village Road	Ossipee	132-40-1	Ossipee Practice Taxable portion	$ 48,400.00	$ 48,400.00	$ 48,400.00
550 Route 16 Lot 2000 Ossipee		266-002	Ossipee land	$ 203,800.00	$ 203,800.00	$ 203,800.00
Route 16 Lot 2001	Ossipee	266-002-001	Ossipee land	$ 203,800.00	$ 203,800.00	$ 203,800.00
21 Cresent Lake Road Wolfeboro		Merged w 231-90 E	Fairtile House*	$ 554,369.00	$ 554,369.00	$ 554,369.00
218 South Main Street Wolfeboro		Merged w 231-90 E	Turner House*	$ 153,227.00	$ 153,227.00	$ 153,227.00
220 South Main Street Wolfeboro		Merged w 231-90 E	Gilbane House*	$ 166,286.00	$ 166,286.00	$ 166,286.00
224 South Main Street Wolfeboro		Merged w 231-90 E	Skelley Blue House*	$ 166,179.00	$ 166,179.00	$ 166,179.00
			Total	**$ 1,923,761.00**	**$ 1,496,061.00**	**$ 1,496,061.00**
			Total Real Property	**$ 2,950,561.00**	**$ 2,522,861.00**	**$ 2,522,861.00**
			*Acquisition Price. Not separately assessed			
			Total All Preaffiliation Assets	**$ 63,299,553.94**	**$ 69,868,008.23**	**$ 74,748,534.51**

Attachment 14

Expected Benefits of Combination 4-19-19 MCH

DRAFT FOR DISCUSSION AND INPUT

D-HH/GOH Combination

Expected Benefits & Discussion of Reserved Powers

26 March 2019

Privileged and Confidential
prepared at the request of counsel

THE CHARTIS GROUP

On the vanguard of thought. The future of healthcare requires nothing less.

Context

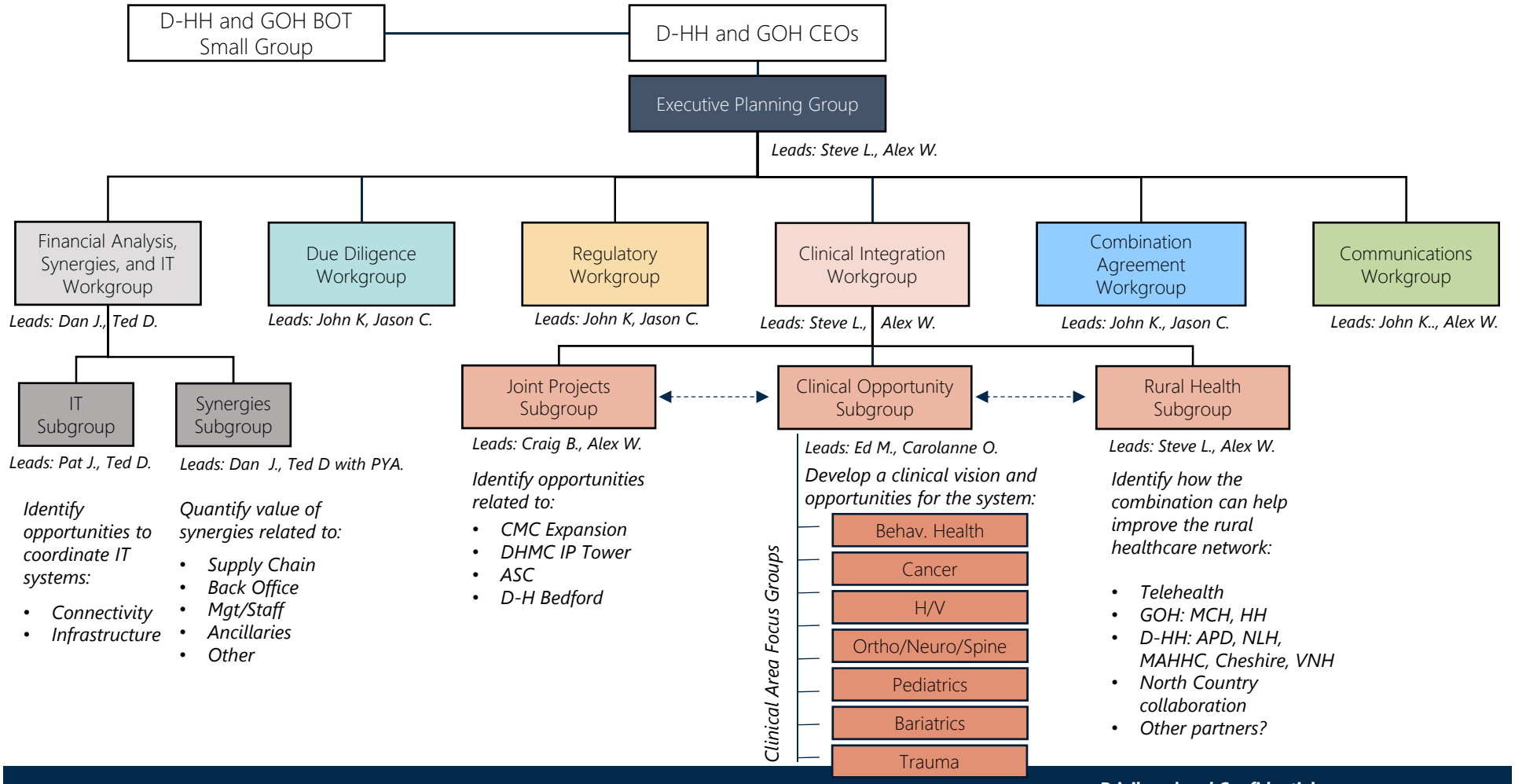
Dartmouth-Hitchcock Health (D-HH) and GraniteOne Health (GOH) entered into a non-binding letter of intent (LOI) on January 23rd to explore a combination that would: (a) improve access by focusing on ways to keep healthcare local, (b) reinforce rural health care, (c) enhance population health/improve quality, and (d) realize efficiencies to make the combination sustainable.

The parties are currently building on the framework outlined in the LOI to develop a Combination Agreement and are aiming to seek approval for this from the D-HH, GOH, and GOH member boards by June 30th so that regulatory filings can be made to begin the regulatory review process.

This presentation is intended to provide a summary of the progress to date and begin to address and discuss questions.

Workgroup Structure

Representatives from all D-HH and GOH member hospitals have been assigned to workgroups to identify opportunities for coming together, as well as prepare the Combination Agreement and regulatory documents.



Key Milestones / Next Steps

Over the coming months, all boards will have ongoing opportunities for updates, review, and discussion, with the goal of seeking final board approval for the combination in late June.

Key Activities	April	May	June
Board Updates	GOH (4/4) CMC (4/18) MCH (4/24)	GOH (5/9) MCH (5/29) HH (5/30) CMC (5/30)	D-HH (6/21) MCH (6/26) CMC (6/27) HH (TBD) GOH (TBD)
Due Diligence		*Complete Document Review & Report Out*	*Final Reports Ready for Review*
Clinical Integration	*Finalize set of opportunities and benefits defined*		
Financial, IT, Synergies Analysis	*Finalize set of opportunities and benefits defined*		
Combination Agreement	*GOH to review/revise draft*	***Complete unsigned version***	***Seek board approval for combination***
Regulatory	*Meetings with NH AG*	*Meet with FTC*	***Prepare to file by 7/1 (upon board approval)***
Communications	*Internal and external communications are ongoing via meet and greets, letters to the editors, website, brochures, etc.*		

Benefits of D-HH/GO to Patients & Communities

D-HH/GO will bring a number of benefits to patients and the communities collectively served.

 Lower Cost of Care	• providing a NH- based alternative for care that is currently provided at more expensive hospitals in MA • directing care more efficiently within the system • finding synergies that allow D-HH/GO to reinvest in the community
 Enhanced Quality and New Services	• improved patient outcomes • greater patient convenience • expansion of population health initiatives • increased access to clinical trials and academic medicine
 Improved Access	• meet pressing community needs (e.g. substance use disorder treatment) • strengthen rural healthcare • expanding workforce/academic training • serving vulnerable populations (e.g. veterans, poor, and underserved)

Benefits of D-HH/GO to Members

Also, there are a number of benefits that individual members will realize by coming together to form a larger system.

 Expand Clinical Resources to Keep Care Local	• Staffing/rotating clinicians through local hospitals • Access to telehealth network (e.g. pharmacy, psych, ED, etc.) • Support with recruiting and retaining workforce
 Broaden Access to Key Resources	• Gain access to capital at a lower cost • Support transitioning to alternative payment models (e.g. training on care models, access to population health monitoring technology, downside risk protection, etc.) • Improve quality through sharing of best practices and resources
 Lower Costs	• Consolidate certain services (e.g. IT, lab, back office, audit, etc.) • Debt refinancing • Group purchasing / supply chain efficiencies • Reduction in professional liability and other insurance, and outsourced services
 Joint Planning	• Leverage system-wide resources to develop unified approaches to complex community needs (e.g. behavioral health, post-acute care, elderly care, patient transportation, etc.)

Case Study: Alice Peck Day Memorial Hospital

As the current D-HH system has evolved there are a number of benefits have been implemented

Professional Liability	Cost to Collect	Debt Refinancing	IT Investment
Lowered annual premium by $500K	Reduced cost to collect by $350K annually	Refinanced $26M of long-term debt under the D-H Obligated Group at a lower cost of capital	D-HH funded 75% of a $10M investment in clinical and financial IT system

Source: D-HH internal financial information

Case Study: Cheshire Medical Center v. Springfield Hospital

Being part of a larger system can provide crucial support to help members weather challenging times and give them the resources needed to make necessary course corrections.

Cheshire Medical Center

2017
-$9M, -10%
Operating Margin

D-HH Responsive Actions

- Organized performance improvement meetings
- Assigned a project manager to help the local team and model their improvement plan
- Deployed D-H's OR VP to assess and offer recommendations
- Helped engage an external firm to improve coding
- $20M advance to cover payroll and bills
- $5M loan to pay MET tax

2018
+$3M, 3%
Operating Margin

Springfield Hospital

2017
-7%
Operating Margin

Worst financial performance of any Critical Access Hospital in VT

No System Support

2018
-1.6%
Operating Margin

Laid off 27 positions and cut pay for staff in Feb 2019, may declare bankruptcy

Source: D-HH internal financial information, GMCB Report (2019), VTDigger (Feb 2019)

Monadnock Community Hospital – Cost Savings Opportunities

Current annual savings under New England Health Alliance (NEAH) vs. stand-alone

Supply Chain	Pharmacy	Other	Total
$197,000 NEAH group purchasing through Vizient/NPC	$491,000 NEAH group purchasing and rebates through NPC pharmacy collaborative	$218,000 NEAH benefits group purchasing $225,000 (2018 est.) Stop loss benefit	

Potential additional savings through D-HHGO system combination (estimates)

Debt Refinancing	IT Investment	Clinical / Admin Services
$2.3M NPV Refinance $24M of long-term debt under the D-H Obligated Group	~$ 7.5M System investment in clinical and financial IT system integration	- Telehealth - Shared physician specialties - Shared services integration

System Infrastructure

In order for the system to provide these kind of benefits, D-HH/GO needs to have certain management and governance structures in place.

System Infrastructure Needed to Realize Benefits:

1. Integrated approach to strategy, finance, and operations
2. Integrated management structure
3. Integrated governance structure with certain powers reserved to the system board

Dartmouth-Hitchcock Health

GraniteOne HEALTH

Example of Reserved Powers

For example, in order for D-HH/GO to be successful and meet the needs of the community, members, and the system, it will need certain reserved powers.

Member CEO	In consultation with the member boards, the D-HH/GO system will have the power to appoint, evaluate, determine the compensation of, and terminate member CEOs.
Assets	In consultation with the member and after taking into consideration the impact on members and their community, the D-HH/GO system will have the power to allocate non-donor restricted assets of members to serve the overall best interests of the system.
Clinical Services	In consultation with the member boards, the D-HH/GO system will have the power to initiate material programmatic and financial decisions at members.

D-HH's Historical Approach to These Topics

D-HH has a demonstrated history of collaborating with local boards around these topics

Member CEO	Cheshire Medical Center and Mt. Ascutney Hospital & Health Center have both selected CEOs since they entered D-HH (due to retirement and the incumbent leaving for another job). D-HH's Chief Strategy Officer worked with the member Board Chair to discuss local needs, system needs, and internal and external candidates. D-HH wanted to appoint someone the member board strongly supported, and in both cases, the recommended CEOs were suggested by the member Board Chair.
Reallocation of Assets	To date, D-HH has never reallocated non-donor restricted assets of members. If it does in the future, it would be to benefit the member and system.
Clinical Services	D-HH has never dictated the closure of a clinical service. Recently, Alice Peck Day Memorial Hospital approached D-HH with quality concerns about its OB program. D-HH worked with the local board to transfer the delivery service to DHMC and retain pre and post-partum care at APD. D-HH and Cheshire invested in telehealth services, transfer center resources and intensivists to increase capabilities at Cheshire and nearly double Cheshire's med/surg census.

Next Steps Related to This Discussion

1. March-May – Development and discussion of the Combination Agreement, which will be finalized in May

2. TBD -- Receive feedback from outside consultants on strategic plan and due diligence.

3. June -- Execute Combination Agreement and expect to begin formal approval process with D-HH, CMC, HH, MCH, and GOH.

Attachment 15

GraniteOne Integration Priorities Summary – 2017

Summary Status Report
October 16, 2017 V3

GraniteOne HEALTH

#	Initiative	Top Deliverables/Goals	Planned End	Schedule	Resources	Budget	High-level Narrative: Budget Components	Key Accomplishments	Upcoming Deliverables
1	Define initial strategy to address short-term needs for primary care		~~August~~ September	✓	✓	✓			
2	Define initial strategy to address short-term needs for specialty care	*Projected start date ~~Sept~~ TBD. Estimated duration 6 months.*							
3	Define initial strategy to address short-term needs for hospital-based services	*Projected start date ~~March~~ TBD. Estimated duration 6 months.*							
4	ID and Implement telehealth capabilities in one service area	1. Identified specialties or areas to use telehealth in the system 2. A telehealth solution implemented in at least one specialty/area identified in #1 (see risks below) for each hospital 3. A business plan/implementation plan to roll-out telehealth to other services/areas 4. Roadblocks or limitations to effectively implementing telehealth (if any)	~~August~~ January 2018	⊘	●	●	1. Telehealth equipment 2. Contracts 3. Licensing fees	1. MCH and Huggins are still working with TeleSpecialists to credential providers 2. Contracts have been finalized by CMC and TeleSpecialists and have been sent to Huggins and Monadnock to review	1. Huggins and Monadnock to review contracts 2. Setting up separate meetings with MCH and Huggins to discuss process, metrics, etc. 3. Answering billing/benefits questions for Huggins 4. Continue credentialing providers
5	Expand telehealth services	*Projected start date ~~September~~ TBD.*							
6	Develop system-wide provider recruitment and retention strategy		June	✓	✓	✓			
7	Create a consolidated contract management system	1. Standardized contract approval process 2. Process for entering contracts 3. Choose a system to use and its design (fields, categories/types of contracts, etc) 4. Set a structure for supporting documentation 5. Prioritized list of contracts to migrate 6. Review of non-disclosures and assignability clauses for contracts to be shared 7. Plan to migrate contracts 8. Documentation of contract management migration process	November	●	●	●	1. Contract System: $15,425.88 for a new contract system set-up/ one-time implementation fee, $15,896.29 for a comprehensive annual licensing fee (i.e. covers all 3 organizations) in Year 1 (annual increases of 6% for upgrades and increases storage space) – Year 1 total of $31,322.17 2. Contract System Invoice received on 5/17 and forwarded to A/P Finance on 5/18. Contract System Invoice amount: $17,973.57. Service and Training invoice to come separately when performed. 3. CobbleStone Systems Corp Invoice received on 6/21/17 for training charges between 5/17/17-6/21/17. Contract System Invoice amount: $906.25. 4. CobbleStone Systems Corp Invoice received on 9/26/17 for training charges between 6/21/17-8/11/17. Contract System Invoice amount: $708.75. 5. Temporary Paralegal Assistance: Anywhere from $50 - $200 per hour. Likely needed on a full-time basis for 3 months to assist with transition of all existing contracts to the new database.	1. 9/13/17 we held an internal call to touch base and regroup in preparation for the data migration for the upload of each hospitals existing contracts. At that time each hospital estimated a 4-6 week timeline to complete their data migration spreadsheets. 2. All hospitals agreed that they did not require temporary assistance at this time. A weekly Webex group work-session call took place on: 9/15. 3. On 10/6/17 we had a Work Session call with Cobblestone in which all provided data to do a test upload of contracts (10 for each hospital). The test upload was successful and we are all currently working to complete our data migration spreadsheets for final upload. 4. CMC anticipates having our data complete by 10/14. Once completed, Debbie will be available to assist MCH and HH if they need additional resources to have their data complete by 11/1.	1. Jessica is working to finalize the GOH Contract Review & Execution Tracking Sheet and policy to be ready for review and final approval by 11/1. 2. During November, the team will troubleshoot any issues with the mass import and finalize training with Cobbletone regarding custom reports and dashboards for our contracts once all uploaded.
8	Provide EMR recommendation to GOH leadership		July	✓	✓	✓			
9	Refinance Huggins debt to reduce interest expense		~~December~~ July	✓	✓	✓			
10	Align fiscal years and develop common budgeting system/ processes	1. Issue consolidated financial statements for GOH as of 9/30/17 2. Establish consistent month-end close process and reporting package for GOH and its affiliates 3. Establish system-wide common budgeting system and processes 4. Deliver consolidated FY 2018 GOH budget and financials	December	●	●	●	**Budgeted: $105,250** (Balance sheet valuations, audit, opening balance valuations). **Billed to Date: $75,000** No budget variances incurred or expected	1. CMC has notified and received approval from its regulatory bodies to change fiscal year end. 2. Trial balance/chart of accounts mapping to align financial statement structure completed. 3. Consolidated reporting for GOH. 4. ERP vendor selection narrowed down to Oracle, with on-going discussions on functionalities, scope of service at each hospital, pricing and timing. 5. Presentation of the fiscal 2018 budget to GraniteOne Finance Committee and Board.	1. Results of 1/1/17 valuation report and related audit procedures for presentation of opening balance sheet – review in process. 2. Documented alignment of budget calendar and process, concluding with consolidated budget year 2018. 3. Documented consolidation process for GOH month end close. 4. Consolidated financial statements for GraniteOne for the period ended 9/30/2017 (internal consolidation by end of calendar 2017, reviewed statements to occur by Feb 2018)

Legend: ✓ Completed ● On Track △ At risk ⊘ Behind

Summary Status Report

October 16, 2017 V3

GraniteOne HEALTH

#	Initiative	Top Deliverables/Goals	Planned End	Schedule	Resources	Budget	High-level Narrative: Budget Components	Key Accomplishments	Upcoming Deliverables
11	Implement a collaborative GOH management structure at the functional level with defined protocols and accountability	1. Organizational Chart 2. Board Committees 3. Management Agreement/Cost Accounting Method 4. Policies – - Cost Structure - Compensation and Evaluation 5. Reporting - Finance - Metrics (quality, cost, access, community benefits)	December	●	●	●	1. Consulting: BNN ($25k)	1. Confirm any additional GOH committee membership 2. Completed Mission, Vision and Values - approved by BOT 3. Draft Allocation of Corporate Overhead and Shared Services 4. Continued efforts on GOH leadership alignment	1. On-going team meetings with GOH management 2. GOH Board meetings in progress
12	Inventory quality measures to track and report internal system-wide benchmarking and share processes/ best practices	Jason Cole is leading this effort. Working with state regulators and other organizations to build the framework for what will be required by the state. Internal efforts across organizations will commence late 2017.	*In Progess, Under Review*	●	●	●			Implementation team to be assembled to move process forward in the fall.
13	Create system-wide org structure for quality and performance improvement	*Projected start date May 2018*							
14	Define system-level Communications/Marketing collaboration processes		May	✓	✓	✓	N/A		
15	Create enhanced employee awareness of the System		May	✓	✓	✓			
16	Evaluate and establish coordinated functions for payer and med staff credentialing	1. Identify different credentialing requirements between facilities for both Med staff and payers 2. Document the processes and policies for med staff and payer credentialing 3. Research and Identify best practices for credentialing 4. Develop new processes and policies 5. Determine a way to share information at the system level (e.g.shared contract, application, form)	Feb 2018	●	●	●	N/A	1. Completed a comprehensive comparative analysis of the initial appointment application material and credentialing requirements for each facility, and identified areas of consensus for alignment, as well as facility specific information to be analyzed to determine if it can be eliminated, or if it must remain as part of the application process. 2. Generated questions for legal counsel to better understand the allowances for sharing information under the GOH Affiliation to inform decision for the future state of the application process. 3. Completed the initial comparative analysis of the provider enrollment documentation requirements and processes for each facility.	1. Discuss the answers from legal counsel on the sharing of information in order to continue to refine and finalize a GOH standard initial application. 2. Continue to discuss the provider enrollment process to identify as many opportunities for efficiencies in the absence of being able to enroll providers with the payors under a single entity.

Legend: ✓ Completed ● On Track △ At risk ⦸ Behind

Attachment 16

GraniteOne Integration Priorities Summary – 2018

Summary Status Report

October 15, 2018

GraniteOne HEALTH

#	Initiative	Top Deliverables/Goals	Planned Start	Planned End	Schedule	Resources	Budget	Budget	*High-level Narrative* Key Accomplishments	*High-level Narrative* Upcoming Deliverables
On-Going from 2017										
2	Define initial strategy to address short-term needs for specialty care	Start November 2017	Nov-17	Apr-18	✓	✓	✓		1.Presented strategies to Integration Council; now implementing (see #8 - part 2)	
3	Define initial strategy to address short-term needs for hospital-based services	*Projected start date Nov 2018-April 2019. Estimated duration 6 months.*	*Nov-18*	*Apr-19*						
4	ID and Implement telehealth capabilities in one service area	1. Identified specialties or areas to use telehealth in the system 2. A telehealth solution implemented in at least one specialty/area identified in #1 (see risks below) for each hospital 3. A business plan/implementation plan to roll-out telehealth to other services/areas 4. Roadblocks or limitations to effectively implementing telehealth (if any)	Jan-17	Mar-18	●	●	●	1. Telehealth equipment 2. Contracts 3. Licensing fees	1. Each facility has had several patients and feel the process works well. 2. Huggins reported that the new process has allowed them to keep some patients at their facility that they might have transferred out	1.Continue to refine the process at both facilities 2. Start discussion next specialty to roll telehealth out to
5	Expand telehealth services	*Projected start date Feb 2018.*	*Apr-18*	*TBD*	●					
12 &13	Inventory quality measures to track and report internal system-wide benchmarking and share processes/ best practices	Jason Cole is leading this effort. Working with state regulators and other organizations to build the framework for what will be required by the state.	Jul-17	*In Progress, Under Review*	●	●	●	N/A	1. Reviewed state's metric & dashbboarding proposal 2. Questions, Comments & Concerns regarding state proposal documented	1. Active dialogue with state to determine what data elements (access to care, quality, cost) need to be reported 2. Follow up meeting scheduled for end of September with State and other hospital systems
New - 2018		**Description**								
1	Evaluate GPO/Non-GPO Alignment and Distributor	Black box analysis that will evaluate opportunities for consolidation of GPOs as well as alignment of materials/supplies purchased outside of GPO	Mar-19	TBD	●	●	●	N/A	1. N/A	1. Re-visit this effort in March/April 2019
2	Evaluate Professional Services Vendors for Consolidation	Review opportunities for alignment on professional services such as Lawyers, Consultants, etc. excluding Clinical Services (e.g. ED) and excluding Auditors.	Jan 2018	Mar 2018	✓	✓	✓	*N/A*	1. Presentation to Integration Council on March 19, 2018.	1. Team to continue to move efforts forward as outlined in presentation to Integration Council on March 19, 2018.
3	Develop GOH Office of Compliance and Risk Management	Develop best practices/policies/procedures to establish central GOH compliance and risk management office.	Jan 2018	Dec 2018	●	●	●	*N/A*	1. Compliance group continues to have a clear focus. Well documented task list & deliverables. 2. Risk team continue to focus on (1) Formalize Organizational Structure for GOH Risk Committee; (2) Develop a Combined Insurance Portfolio; (3) Develop GOH Risk Education Program; (4) Develop GOH Risk Assessment Strategy & (5) Develop Standardized Risk Dashboards.	1. First draft of Risk IC presentation created. 2. Compliance team preparing an update for October 15th IC meeting.
4	Evaluate alignment of Health Insurance and Other Benefits	Inventory current employee benefit offerings and determine scope of what can/cannot be aligned across GOH. Team to provide scope recommendation of which benefits (health insurance, 403B etc.) can/should be aligned within 4 months. Efforts would need to begin ASAP to make a full recommendation in August 2018.	Apr-19	TBD	●	●	●	N/A	1. Executive decision has been made to pause this effort due to competing priorities across GOH groups. 2. Effort will be revisited within the next 8 months	1. Revisit this effort in April 2019
5	Develop a System-wide Coding Strategy	Develop business case for sourcing coding and coding audit resources at CMC rather than through vendors.	Jan 2018	Jun 2018	●	●	●	*N/A*	1. Presentation to Integration Council on June 18, 2018. 2. Cost Benefit Analysis draft has been created	1. Finalize and distribute Cost Benefit Analysis
6	Provide Collaboration Opportunities between Contracted Radiology	Team to provide a recommendation regarding Huggins Hospital contracting with Southern NH Radiology with the establishment of one GOH shared contract on the roadmap for future efforts.	Jan 2018	Mar 2018	✓	✓	✓	*N/A*	1. Presentation to Integration Council on March 19, 2018.	1. Team to continue to move efforts forward as outlined in presentation to Integration Council on March 19, 2018.
7	Primary Care Strategy Implementation (part 2)	Implementation of Primary Care Strategy developed in 2017	Oct 2017	On-going	●	●	●		1. Discussed any changes 2. Working on updated numbers for covered lives.	1. Continue to discuss any changes 2. Ensure aligned to specialty strategies 3. Review progress to targets
8	Specialty-Care Strategies Implementation (part 2)	Implementation of Specialty-Care Strategy developed in Nov 2017-April 2018	May 2018	Oct 2018	●	●	●		1. Discussions are still happening around a general surgery solution. 2. The other service lines (Urology, GI, Breast, Bariatrics) are still moving forward. 3. Dr Silversmith is set to start at Huggin the end of September 3. Additional discussions beyond the original 5 specialties are being had around lab and anesthesia, endocrinology and pulmonary	1. Continue executing next steps for deliverable in September 2018 - Gen Surg - develop a system solution including call coverage - Urology - All working with Manchester Urology who is looking for providers - Breast - All working towards process once Dr Ryan on-board - Bariatrics - All working with NEWMI to define relationship
9	Patient Repatriation	Transfer patients back to originating hospital based on clinical outcomes and need.	May 2018	Dec 2018	●	●	●		1. Finalized repatriation checklist 2. Validated reimbursement model 3. Internal compliance review and analysis completed	1. Communication to GOH final draft due 10/10 2. Initial trial scheduled to start 10/15
10	EMR Implementation	Implementation of Allscripts EMR at CMC, HH	Oct 2017	April 2019	●	●	●	CMC = $16.2M HH = $2.8M	1. OnBase HR: Back scanning of historical employee files…completed through letter 'H' 2. OnBase HIM: Began linking amulatory patients numbers for both HH and CMC to their respective Acute Care medical record numbers. 3. EMR: Finalized list of all remaining tasks to reach go-live. - CMC Go-live Target 3/1/19.	1. OnBase HR: Continue HR back scanning employee charts 2. OnBase HIM: Continue ambulatory eMPI linking and set completion target date. 3. EMR: Track all remaining tasks (ex: 3M coding, Integrated testing, etc.) for CMC go-live. Establish target date for HH. Report out to IC on project status, dates and costs.
11	ERP Implementation	Implementation of new ERP system. CMC and HH - Oracle, MCH - Kaufman Hall, budgeting only	Dec 2017	Jan 2019	●	●	●	CMC = $1.4M HH = $520k	Go-live 10/1/18. 1.HH - All modules live. 2. CMC - All modules (except benefits and Payroll) live. 3. Completed Parallel payroll testing for CMC.	1. Continue monitoring production environment (specifically performance) 2. Continue payroll/Benefits preparation for CMC on 1/1/19.
12	Develop cyber security best practices across GOH	Standardize cyber security best practices across GOH.	Jan 2018	Jun 2018	✓	✓	✓	N/A	1. Presented plan to integration council on 7/16/2018. HH, MCH and CMC will continue efforts to coordinate cyber changes and budget/prioritize where appropriate.	1. Complete

Legend: ✓ Completed ● On Track △ At risk ⦸ Behind

Attachment 17

GraniteOne Integration Priorities Summary – 2019

GOH Integration Priorities Summary Status Report

smartsheet

	#	Initiative	Top Deliverables/Goals	Phase	Status	Planned Start	Planned End	Schedule	Resources	Budget	Budget Comments	Key Accomplishments	Upcoming Deliverables
2	3	Define initial strategy to address short-term needs for hospital-based services	Projected start date Nov 2018-April 2019. Estimated duration 6 months.	Strategy	Not Started	TBD	TBD					1. N/A	1. N/A
4	5	Expand telehealth services		Action	Active	09/01/18	09/01/19					1. Still discussing tele-psych options 2. Dr. Kleeman presented at Huggins about tele-neurospine 3. Discussed potential for Tele-NEWMI and tele-cardiology	1. Continue to explore tele-psych, tele-NEWMI, and tele-cardiology 2. Continue to advance tele-neurospine at both MCH and Huggins 3. Explore tele-dermatology and tele-lipids
5	12 & 13	Inventory quality measures to track & report internal system-wide benchmarking & share processes/ best practices	Jason Cole is leading this effort. Working with state regulators & other organizations to build the framework for what will be required by the state.	Strategy	Active	07/01/17	12/31/19					1. Reviewed state's metric & dashbboarding proposal 2. Questions, Comments & Concerns regarding state proposal documented	1. Active dialogue with state to determine what data elements need to be reported 2. Need a follow up meeting with State & other hospital systems
10	9	Patient Repatriation	Transfer patients back to originating hospital based on clinical outcomes & need.	Action	Active	05/01/18	09/01/19					1. GOH Back Transfers went live on 10/16/18 2. Two back transfers to date. One was successful and followed the process. The retro look at reimbursement showed that both hospitals received the expected payments. The second transfer seems to not have followed the proper process and as a result, there were issues that affected patient and patient family experience and workflow. 3. There has been a retrospective look at this by both hospitals.	1. The next step is to bring the team together to discuss the breakdowns and develop mitigation strategies. 2. CMC Case Management is working to improve transfers overall and is creating standard work tools for GOH Back Transfers as part of this.
11	10	EMR Implementation	Implementation of Allscripts EMR at CMC, HH	Action	Active	10/01/17	07/01/19				CMC = $16.2M HH = $2.8M	1. CMC dropped bills beginning 8/23/19 and have received begun receiving payments. Continued phase I post live support. 2. Continued testing and build efforts for HH. 3. CMC continued testing and training for Ambulatory (phase II) go-live	1. CMC continue post live support, with continued focus on ED and Rev Cycle. 2. CMC Drop production bills to payers 3. CMC migrate phase II (ambulatory) build to production. 4. CMC confirm date of phase II (ambulatory go-live) 5. HH continue prep and build for acute and ambulatory (phase I and II) 6. HH evaluate readiness and establish go-live date for Phase I and II
15		System-wide Coding Office Implementation (part 2)	Initial implementation of a GOH Coding function.	Action	Active	01/01/19	12/31/19					1.CMC continues to use HMI 2. CMC successfully make it through Phase 1 Allscripts and 3M transition 3. CMC hired a Professional & Facility Coding Manager 4. Huggins continues to cross train coders within the department to cover all services. 5. Huggins has hired independent contract coders as well as replaced staff to help with volume and backlog. 6. MCH is current with coding and using HMI and AVEC when needed	1. CMC is preparing for go-live Phase 2 (physician practices) . 2. MCH is looking for an on-site coder 3. Huggins is working to reduce/eliminate its outsourcing of coding to NThrive.
16		Evaluate health insurance benefit alignment (part 2)	Explore opportunities in brokerage services	Evaluation	Not Started	TBD	TBD					1. Executive decision has been made to pause this effort due to competing priorities across GOH groups.	1. Huggins to keep existing broker (CGI) 2. CMC to sign 2 year agreement with existing broker (Mercer)
17		Evaluate GPO/Non-GPO Alignment & Distributors	Black box analysis that will evaluate opportunities for consolidation of GPOs as well as alignment of materials/supplies purchased outside of GPO	Evaluation	Not Started	TBD	TBD						1. Effort has been paused
18		Build system-wide infrastructure for enhanced communication/collaboration between specialists, primary care & hospital-based services to manage patient care	TBD	Action	Not Started	TBD	TBD					1. Initiative scored & selected for consideration by GOH IC	1. Initial charters drafted & distributed to team
19		Evaluate & act to improve GOH leakage	TBD	Action	Not Started	TBD	TBD					1. Initiative scored & selected for consideration by GOH IC 2. Drafted initial charters	1. Distribute charters to team for revisions
20		Define long-term strategy for specialty services within the system	TBD	Strategy	Not Started	TBD	TBD					1. Initiative scored & selected for consideration by GOH IC	1. Distribute charters to team for revisions
21		Develop specialty care telehealth capabilities/competencies	TBD	Action	Not Started	TBD	TBD					1. Initiative scored & selected for consideration by GOH IC	1. Distribute charters to team for revisions
22		Develop a platform for larger population health management (directing continuum of care to post-acute, PT, other ambulatory services, etc.)	TBD	Action	Not Started	TBD	TBD					1. Initiative scored & selected for consideration by GOH IC	1. Distribute charters to team for revisions
27		Implementation of GOH Office of Compliance & Risk (part 2)	Initial implementation of a system-wide Risk office.	Action	Not Started	01/01/19	09/01/19					Risk workground put this portion on hold. We are already duplicating a lot of the work that we did for GOH and believe that if we continue with the GOH initiative, we will be duplicating even more work. Or, we will make changes that will make the GOH risk work irrelevant.	

	#	Initiative	Top Deliverables/Goals	Phase	Status	Planned Start	Planned End	Schedule	Resources	Budget	Budget Comments	Key Accomplishments	Upcoming Deliverables
28		Professional Services Vendors for Consolidation (part 2)	Consolidate professional services identified from Part 1 initiative.	Action	Not Started	**TBD**	**TBD**						
29		Provide Collaboration Opportunities between Contracted Radiology (part 2)	Finalize & execute Huggins Hospital short-term contract Confirm resources from Southern NH Radiology for Huggins Finalize & execute system-wide GOH Master Services Contract	Action	Active	**TBD**	**TBD**						
30		Evaluate potential for CMC to become a credentialed lab for Monadnock & Huggins employee benefits.	Extend CMC employee lab discount to both Huggins & Monadnock employees	Action	Not Started	**TBD**	**TBD**						
31		Evaluate & potentially pursue opportunities for Huggins integration of reference lab to CMC	Identify tests that can be performed at CMC vs. outside vendors Implement processes & procedures for reference tests to be performed at CMC	Action	Active	10/01/17	04/01/19						1. Huggins Lab will utilize Quest lab for reference lab testing not available at CMC. This will occur when the multisite environment goes live. 2. Reference tests to be performed at CMC include Pathology, Microbiology, & any test previously performed at LabCorp that is available through CMC. This will occur when multisite environment goes live.
32		Explore Laboratory opportunities to st&ardize equipment & supplies for efficiency & cost savings	Reduce expenses by collaborating with the Materials Management Affinity Group	Evaluation	Not Started	06/03/19	01/31/20						
33		Post Go-Live ERP Improvements	TBD	Action	Not Started	01/01/19	09/01/19						
34		Post Go-Live EMR Improvements	TBD	Action	Not Started	04/01/19	09/01/19						

Attachment 18

Huggins Hospital Quality Dashboard

Huggins Hospital 2019 Quality Dashboard

Quality Measurements	Target	Reporting Quarter Q4 2019	Trends	Comments
Falls - Acute inpatient falls with minor or greater injury (excluding obs and swing). Target is based on what Huggins Hospital would like to obtain. Peer Network rate of falls is 1.60. State rate is 0.74.				
Surgical Site Infections (SSI) - Reported via NHSN: Surgical site infections include from three surgeries: hysterectomies, colon surgeries and knee replacements. This does not include SSI from any other types of surgery. National Mean for surgical site infections is 0.8				
Healthcare Associated Infections: Many types of invasive devices may be required to treat patients and aid in recovery. These devices may include catheters or ventilators. Because these devices may remain in patients for a number of days, patients can be at risk for getting an infection. The infections this metric looks at are Ventilator Associated Pneumonia, Central Line Associated Blood Stream Infection, Catheter Associate Urinary Tract Infection, and C-Diff Infection. National Mean for HAC is 0.8				
LWOBS: Patients that have left the Emergency Department prior to being seen by a provider				
Door to Discharge (Discharged Patients): Median time patient walks in to department to the time they walk out after discharge. **Admit Decision Time:** Median time the decision to admit the patient is made by the MD to the physical time the patient leaves the Emergency Department to the unit they are admitted to.				
Median Time to EKG- This measure looks at all patients who come in to the Emergency Department with a complaint of chest pain, and get an EKG. This measure is directly tied to patient outcomes. The quicker an EKG ca be performed, the quicker treatment can be initiated for a serious heart condition. National Average is 8 min				
ED Stemi Transfer Time- Primary percutaneous coronary intervention (PCI) is the most effective treatment available for acute ST-elevation myocardial infarction (STEMI). Patients have better odds of survival if they receive reperfusion within two hours of first medical contact, after which the opportunity for salvaging the heart muscle steadily diminishes. To meet that time window, patients must be either transported directly to a PCI-capable hospital or transferred from a referring hospital as soon as possible after symptoms develop. National Mean is 64 min. Huggins Hospital goal <20min				

Huggins Hospital 2019 Quality Dashboard

Quality Measurements	Target	Reporting Quarter Q4 2019	Trends	Comments
Reportable Events: These are any unanticipated events in our Organization resulting in death or serious physical or psychological injury to a patient or patients, not related to the natural course of the patient's illness.				
HGBA1C all outpatients-Hemoglobin A1c is a blood test level is routinely performed in people with type 1 and type 2 diabetes mellitus. Blood HbA1c levels are reflective of how well diabetes is controlled. This measure looks at the number of diabetics who have an uncontrolled HGBA1C (>9%).				
Hypertension-High blood pressure is a common and dangerous condition. Having high blood pressure means the pressure of the blood in your blood vessels is higher than it should be. This common condition increases the risk for heart disease and stroke, 2 of the leading causes of death for Americans. This measure looks at the number of eligible patients with HTN who are controlled BP <140/90				
New Patient Appointments- This is a percentage of total new appointments over total office visits. This number is meant to represent Huggins Hospital new business. Baseline for this metric was 4.69%				
Medication Events- This number includes all medication events across the organization that get reported through the incident reporting system. These events range from errors in dose, patient, time, and drug, to transcribing errors, allergic reation, adverse drug reaction, missed doses and errors in scanning. There is no data on a national mean for this metric so we will benchmark against ourselves. The goal is to have 0 SEVERE Medication Events. **Severe:** Events interrupt the participant's normal daily activities and generally require systemic drug therapy or other treatment; they are usually incapacitating				
Whats New? Antibiotic Stewardship program hosted by John Hopkins . Antibiotics are a precious resource and can be critical for improving the outcomes of patients with serious infections. However, antibiotics also have the potential to cause patient harm, including allergic reactions, Clostridium difficile infections, and antibiotic resistance both at the individual patient level and for society as a whole. We want antibiotics to be effective for future generations, and that is only possible if we use antibiotics judiciously.				