

**REPORT OF THE ATTORNEY GENERAL,  
CHARITABLE TRUSTS UNIT  
REGARDING THE GOVERNANCE OF LRGHEALTHCARE**

**April 21, 2022**

**I. INTRODUCTION**

On October 19, 2020, LRGHealthcare (“LRGH”), which operated hospitals in Laconia and Franklin, filed for relief under Chapter 11 of the Bankruptcy Code following several years of poor financial performance. The bankruptcy filing marked the first financial failure of a nonprofit hospital in New Hampshire since the closure of Newport Hospital in 1991. There may be grave consequences from the collapse of a nonprofit so vital to the community. Therefore, the Charitable Trusts Unit initiated a review to determine whether LRGH’s governing board had breached its fiduciary duties and whether any insights could be gained from LRGH’s experience. This report is a summary of the findings of the Charitable Trusts Unit.

In conducting its review, the Charitable Trusts Unit considered information dating from 2005 through 2021, including LRGH board of trustee materials (board and committee meeting minutes, board retreat presentations, and board advisor presentations), monthly financial reports, audited financial statements, bond financing and refinancing documents, and bankruptcy court filings. The Charitable Trusts Unit retained retired hospital executive John Marzinzik to review all of this information and provide an assessment. Finally, the Charitable Trusts Unit interviewed certain former LRGH trustees and executives.

## II. BACKGROUND

### A. The Corporation

In 1893, the Legislature established Laconia Hospital Association as a voluntary corporation. Ch. 147, Laws 1893. Laconia Hospital Association, which later became known as LRGH, is a charitable organization within the meaning of RSA 7:21, II (b) and is exempt from federal income taxation under section 501(c)(3) of the Internal Revenue Code. For more than 125 years, LRGH operated Lakes Region General Hospital, a community acute care hospital in Laconia. In 2020, the hospital had a licensed bed capacity of 137 beds, 50 of which were staffed, and LRGH was Laconia's largest private employer with over 1,400 employees.

In 2002, LRGH became the surviving entity of a merger involving Franklin Regional Hospital ("FRH"). FRH was incorporated as Franklin Hospital Association in 1909 and operated a critical access hospital in Franklin for more than 110 years. As of 2020, FRH had 25 general beds, 20 of which were staffed, plus a 10-bed inpatient psychiatric unit, 8 of which were staffed.

### B. Leadership and Governance

For more than 25 years, LRGH's leadership team remained stable. From 1989 until his retirement in 2014, Thomas Clairmont served as the chief executive officer ("CEO") of LRGH. At the time of his appointment as CEO, he was a longstanding LRGH employee, having begun his career at LRGH in 1971, when he was hired as an accountant for the hospital. Henry Lipman likewise was employed by LRGH for many years. He joined the hospital in 1984, when he accepted a position as budget planning director. In 1997, he was promoted to serve as LRGH's chief financial officer ("CFO"), a position that he held until 2017 when he resigned from LRGH. Since 2017, Mr. Lipman has served as the Medicaid Director at the New Hampshire Department of Health and Human Services.

The lengthy tenure of the two top administrators at LRGH is highly unusual in the hospital industry. According to a study conducted by the American College of Healthcare Executives (“ACHE”), in 2005, the average tenure of a healthcare CEO was approximately 5 1/2 years, and the turnover rate was at 14%. *See, The Impact of Hospital CEO Turnover in U.S. Hospitals, 2005.*<sup>1</sup> At that time, only 3.4% of hospital CEOs had a tenure of 20 or more years. *Id.* By 2013, the turnover rate had risen to 20%. *See* ACHE, June 28, 2021 Release.<sup>2</sup> ACHE’s study found that CEO turnover can have a negative effect on other executive personnel, could delay strategic planning and development, and could provide an opportunity for competitors to take advantage of unstable circumstances. *See, The Impact of Hospital CEO Turnover in U.S. Hospitals, 2005.* However, the report also concluded that the departure of the CEO can have many positive effects, including improvements in financial performance, hospital culture, employee morale, and relations with the medical staff, board, and community. *Id.*

The LRGH board of trustees was responsible for governing the corporation and for supervision of the CEO. Over the years, the number of members of the board ranged from 22 in 2014 to 15 in 2019. The board was comprised of business leaders, community representatives, and medical professionals, and a portion of the members enjoyed lengthy tenure on the board. While some of the community representatives and medical professionals on the board had no experience or education in finance, the majority of the board’s finance committee consisted of people with a background in finance.

#### C. LRGH’s Financial Condition from 2005-2009

In 2005, the board of trustees participated in a lengthy retreat facilitated by a well-known health care consultant. At the retreat, board members received training about their

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<sup>1</sup> [The Impact of Hospital CEO Turnover in U.S. Hospitals.](#)

<sup>2</sup> [ACHE Report on Hospital CEO Turnover Rate.](#)

responsibilities as board members, conducted a Strengths, Weaknesses, Opportunities, and Threats (“SWOT”) analysis, and engaged in a comprehensive strategic planning process. With respect to weaknesses, the board recognized that LRGH’s hospital facilities were tired and unattractive to patients, and the board was concerned that patients who could afford to travel would migrate to Concord Hospital. They also recognized that the emergency rooms were outdated and that patients desired single rooms. The board determined that the information technology system did not meet current standards in the industry and that it needed to be updated.

At the time of the 2005 retreat, LRGH was not experiencing financial distress, but Mr. Lipman’s long-term financial forecast suggested that LRGH would be required to grow its operations and reduce staffing and expenses. He indicated that capital expenditures to modernize the facilities and improve information technology could be funded from philanthropy and debt.

In April 2006, the board developed a comprehensive facility master plan that would include new construction, renovations of existing space, and new furniture, equipment, and information technology systems. The estimated cost was \$97 million. The board determined that the plan would be carried out over a 10-year period, and LRGH would pay half the cost through financing and the other half through operations and philanthropy.

Over the course of the next year, it became clear to the board that the plant and mechanical support systems were deficient and required updating. Interestingly, the upgrades to the services and systems were not included in the annual budget, even though the necessity for the upgrades should have been anticipated.

During fiscal year (“FY”) 2007, LRGH decided to retain a new auditor, Baker Newman & Noyes, a firm that has substantial experience in auditing hospitals. The FY 2007 audit reflected 6 material weaknesses and 5 significant deficiencies. The audit for FY 2008 reflected 1 material weakness and 12 significant deficiencies, 4 of which were repeated from the FY 2007 audit. There is no indication in the board meeting minutes that any of the board members raised any concerns about the audit reports.

On September 24, 2007, the LRGH board approved an application for a certificate of need (“CON”), a requirement at that time for larger hospital capital improvement projects. The CON would cover a new patient tower and lobby in Laconia, new facilities in Franklin, and a new clinic in Meredith. The trustee who presented the CON summary to the board is a certified public accountant. He noted during his presentation to the board that the cost would be financed through debt, operations, and philanthropy. LRGH submitted the CON application to the State of New Hampshire in October 2007.

By late 2007 and early 2008, the board became aware of headwinds facing them. LRGH was not experiencing patient growth or increased revenue, and it confronted increasing competition for commercial insurance patients from Concord Hospital. The region’s population was getting older, with a larger proportion of lower-reimbursement Medicare and Medicaid patients. To make matters worse, at a February 25, 2008, executive committee meeting, the trustees learned that a change in the Medicaid formula would mean that moving forward, the Laconia hospital would experience an annual loss of approximately \$1.2 million. Mr. Lipman told the executive committee that these cuts would offset potential revenue gains from the proposed hospital expansion. He also mentioned that changes to the Medicare wage payment system could impact LRGH by another few million. During an executive session following the

meeting on February 25, 2008, board members questioned whether to continue pursuing the large expansion project in light of the discouraging financial news. Two days later, the *Laconia Daily Sun* published an article regarding the anticipated Medicaid cuts in which Mr. Lipman was quoted as saying that “[LRGH] would be in the red as soon as they took effect.”

In spite of the questions concerning LRGH’s financial future, at the next board meeting on March 28, 2008, the board approved spending \$1.4 million for the CON project design and \$3.2 million in other capital projects. In addition, the board approved the terms for the restructuring of its 1993 \$31.2 million bond issue through a swap arrangement.<sup>3</sup> The minutes of the March 28, 2008, board meeting do not reflect any discussion among board members regarding the concerns raised during the February 25, 2008, executive session or the newspaper article in which Mr. Lipman was quoted regarding the impact of anticipated Medicaid cuts.

In April 2008, the board approved borrowing \$17 million to pay for the refinancing of the 1993 bonds with the swap agreement, the \$8 million purchase and renovation of the Hillside Medical Park condominium, and the \$5 million purchase of capital equipment. In August 2008, the board approved the construction of a new operating room in Laconia at a cost of \$1.1 million and the purchase of space in a local medical office building for \$606,860.

The foregoing spending decisions took place in the midst of the global financial crisis that had emerged in the spring of 2008. The board members were aware of the likely financial impact of the crisis on the hospital. After returning from the New Hampshire Hospital Association conference in the fall of 2008, Mr. Clairmont reported to the trustees that one of the speakers at the conference told the hospital executives and board members in attendance that

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<sup>3</sup> A swap is a complicated transaction that involves an agreement between two parties to exchange sequences of cash flows for a set period of time. Usually, at the time the contract is initiated, at least one of these series of cash flows is determined by a random or uncertain variable, such as an interest rate, foreign exchange rate, equity price, or commodity price. A swap can be a way to manage interest rate risks, but there are risks inherent in entering into such agreements.

“the current system is not sustainable,” and “reservation and growth of cash is critical.” The speaker also said that if he “were a CEO with a building project on the table, he would put it on hold.”

By November 2008, LRGH’s operating margin was declining and was unfavorable to budget. LRGH’s days of cash on hand were down to 74, well below the average for hospitals,<sup>4</sup> and its leverage ratio was out of compliance with the bond covenants. As a result, the board voted to refrain from making contributions to the employee pension fund and the workers’ compensation trust. Nevertheless, at that same meeting, the board approved \$913,000 in spending for various new capital projects.

In January 2009, Mr. Clairmont asked the board to put the expansion project on hold for six months, and the board agreed. Conventional financing had become impossible for LRGH, given its weak financial position. Yet instead of reshaping priorities, Mr. Lipman used the time to lock down alternative financing. He focused on the Federal Housing Administration (“FHA”) Section 242 hospital mortgage insurance program financing through the United States Department of Housing and Urban Development (“HUD”). The financial performance requirements for the HUD insured bond were much looser than that appearing in typical bond covenants.

At the June 22, 2009, board meeting, Mr. Lipman presented a finance report that reflected a \$2.1 million loss for the month. Nevertheless, the board approved a certificate of vote for the HUD financing in the amount of \$170 million to construct and equip a patient tower in Laconia, renovate and upgrade Franklin’s emergency department, replace and expand an outpatient facility in Meredith, pay off certain bond issues, and finance the capitalized

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<sup>4</sup> In 2008, the median days cash on hand for hospitals was 110 days. “40 Hospital Benchmarks,” Becker’s Hospital Review (10/31/2011) (citing 2010 American Hospital Association Environmental Scan, based on 2008 data).

interest, debt service, bond issuance costs, and credit insurance. An independent auditor subsequently prepared a financial feasibility study and concluded that sufficient funds could be generated to meet LRGH's operating expenses, debt service, working capital needs and other financial events. However, the financial forecast was based on assumptions provided by the CFO and the LRGH finance team, and the report specifically stated that the conclusions in the report were dependent on future events, which could not be assured.

By August 2009, senior management became actively involved in cost reduction measures. Among other financial issues management needed to address, LRGH had not maintained adequate funding of reserves for the employee pension fund and workers' compensation trust. As a result, it was required to use \$3.1 million from its unsecured line of credit and operating funds to provide that funding.

By the board's September 28, 2009, the HUD loan had been approved. The board voted to approve LRGH's FY 2010 budget that included \$10 million for capital equipment that was outside the previously-approved capital improvement project. At that same meeting, Mr. Lipman projected that LRGH would experience in FY 2010 a positive financial margin of \$5.3 million. In fact, LRGH experienced a loss of \$12.7 million for that year.

In 2011, the board's annual retreat involved a presentation about the American Hospital Association's report on "Hospitals and Care Systems of the Future." The presentation highlighted likely future changes in store for hospitals and the need for board members to address anticipated challenges, including management of risk. The board voted that LRGH should become part of the Granite Healthcare Network, LLC,<sup>5</sup> a collaboration of 5 health

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<sup>5</sup> Granite Healthcare Network was established as a joint venture in April 2011; Granite Healthcare LLC was created as an administrative services organization in August 2011.

systems, with a mission “to lead the transformation of health care delivery in the communities we serve by leveraging collective intellectual and clinical resources to improve quality, cost effectiveness, and access beyond what any one of us could achieve individually.” In 2011-12, the members of the Granite Healthcare Network were Concord Hospital, Elliot Hospital, Southern New Hampshire Health System, Wentworth-Douglass Hospital, and LRGH.<sup>6</sup> Among other things, Granite Healthcare Network partnered with Tufts Health Plan to create Tufts Health Freedom Plan, a healthcare insurance plan for the network’s members and the business community.

D. LRGH’s Financial Collapse 2014-2019

The \$51 million in capital projects financed through the Series 2009 Bonds covered extensive renovations and expansion of the Laconia hospital, including a new lobby and patient tower, as well as renovations to the Franklin hospital and a new outpatient clinic in Meredith. Those renovations were completed by 2012. Unfortunately, the new facilities and renovations failed to generate increased revenues sufficient to match the increased financing costs of the HUD-insured bonds.

In 2014, the LRGH board conducted a survey of its leadership style and culture. In June 2014, the board reviewed the results with an outside consultant. The consultant discussed with the board the need for it to determine what type of culture it sought for LRGH and the steps for accomplishing the goal. The survey concluded that LRGH’s leadership was more “reactive” than “creative.”

In August 2014, Mr. Clairmont resigned as CEO. The board appointed Chuck Van Sluyter to serve as interim CEO while it conducted a search for a new CEO.

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<sup>6</sup> In 2014, Elliot Hospital withdrew from Granite Healthcare Network as a full member and became an affiliate shared service member. Catholic Medical Center joined the network as a full member in 2014.

In March 2015, Mr. Lipman's report to the finance committee regarding LRGH's profitability and cash position was grim. He noted that LRGH experienced significant losses, with fiscal year to date operating expenses of \$2.5 million unfavorable to budget.

During 2015, LRGH management and the board were deeply involved in investigating and choosing an electronic medical record ("EMR") system for LRGH. Because LRGH collaborated with Speare Memorial Hospital ("Speare") in Plymouth in connection with certain clinical services, LRGH and Speare proposed to share the cost of a new EMR. It is not clear from the records why LRGH did not pursue a collaboration with another member of the Granite Healthcare Network for an EMR system.

The original proposal for a new EMR system as presented to the board on April 27, 2015 called for LRGH and Speare to share the capital and operating costs of the Cerner EMR system on an equal basis (50/50). On May 21, 2015, a final proposal for the shared cost of the EMR was submitted to the finance committee for consideration. The finance committee was informed that the capital cost of the Cerner system was estimated to be \$15.8 million, that the annual operating cost was estimated to be \$15.7 million, and that Speare had approved the proposal. However, contrary to the discussion at the April meeting, the cost split had been revised such that LRGH would pay 80% of the costs, and Speare would pay only 20%. Although the minutes did not reflect the reason for the change in the split percentage, according to Mr. Lipman, the split was based on gross revenue and LRGH's strategy to entice Speare to make referrals to LRGH, rather than to Concord Hospital or Dartmouth-Hitchcock Medical Center. The proposal ultimately was approved by the finance committee and recommended to the full board, which also approved the agreement.

Because of LRGH's declining financial condition, the board sought to reduce the interest rate on its HUD loan through refinancing. In September 2015, it was successful in refinancing the loan, but at an upfront refinancing cost of \$15.6 million in cash.

By the end of FY 2015, LRGH's financial statements reflected a deficit of over \$30 million and a decline in its net assets of \$37 million. Faced with few good options, the LRGH board of trustees began to take drastic action. Beginning in 2016, LRGH hired Prism Healthcare Partners, Kaufman Hall, and Quorum Health Resources, all nationally-recognized health care consulting firms, to cut costs and improve LRGH's balance sheet. Thereafter, LRGH cut vascular services, surgical services in Franklin, and obstetrics in Laconia. In addition, LRGH substantially reduced its staffing levels and reduced employee benefits.

During this period of time, LRGH experienced several changes in its leadership. In October 2015, LRGH hired Seth Warren as its CEO. Months later, Mr. Warren left LRGH. In June 2016, LRGH hired Kevin Donovan as its President and CEO. Mr. Donovan's goal as CEO was to identify a healthcare partner for LRGH in order to preserve healthcare in the region.<sup>7</sup> Henry Lipman left LRGH one year later.

LRGH's losses compounded in 2018 (\$12.8 million) and 2019 (\$19.7 million), and its net assets plummeted by similar amounts. By March 2019, the organization's days of cash on hand had declined to the single digits. Only through the cost-cutting measures implemented in recent years, combined with the closure of programs and state and federal emergency pandemic funding, was LRGH able to limp along until its Chapter 11 filing in 2020.

In June 2018, as the financial situation worsened, the LRGH trustees retained Kaufman Hall to lead a process for the sale of the hospitals. While Kaufman Hall reached out to 19 potential acquirers, in the end, no entity offered an amount sufficient to pay off LRGH's

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<sup>7</sup> See "Hospital's Chief Administrator Donovan Leaving," *Laconia Daily Sun* (March 14, 2022).

extensive liabilities. As a result, by mid-2019, the LRGH trustees concluded that its only viable option was an asset sale in conjunction with a bankruptcy filing. Through negotiations, Concord Hospital emerged as the only entity willing to serve as the stalking horse bidder as part of the bankruptcy process. On October 19, 2020, LRGH filed in the United States Bankruptcy Court for the District of New Hampshire a Chapter 11 voluntary petition for relief, along with a motion to sell substantially all of its assets pursuant to an auction process established under section 363 of the Bankruptcy Code. Included with the motion was Concord Hospital's stalking horse bid.

The Bankruptcy Court ultimately approved the asset sale to Concord Hospital, and after the Charitable Trusts Unit issued its report on March 29, 2021, the asset sale transaction between LRGH and Concord Hospital closed, effective May 1, 2021. The two hospitals formerly owned by LRGH are now known as Concord Hospital-Laonia, and Concord Hospital-Franklin, and on May 18, 2021, the remnants of LRGH changed its name to HGRL.

### **III. CAUSES OF LRGH'S FINANCIAL DISTRESS**

In a Declaration filed with the Bankruptcy Court in connection with the Chapter 11 filing, Kevin Donovan attributed LRGH's financial collapse to a number of factors, including the decisions of prior management.<sup>8</sup> His Declaration provided, in pertinent part:

36. [LRGH] has experienced a tumultuous five to ten years, all beginning with decisions by prior management to make significant investments in inpatient services and facilities at a time when patient demographics and medical trends indicated more reliance on outpatient services and decreased hospital use. Soon thereafter, [LRGH] found itself caught in a downward spiral of increasing costs, decreasing reimbursement, shrinking service lines and volume "leakage" to other communities. A primary driver of cost growth was the implementation of a massively expensive electronic medical record which ultimately consumed approximately nine percent of total organizational revenue annually (two to three times the industry average).

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<sup>8</sup> As discussed above, Mr. Donovan served as the President and CEO of LRGH from 2016 to May 2021. Tom Clairmont retired as President and CEO in 2014, and Henry Lipman left LRGH in 2017. After the asset sale, Mr. Donovan served as Chief Administrative Officer for Concord Hospital-Laonia and Concord Hospital-Franklin. In March 2022, he announced his resignation.

Other board members interviewed for this report agree that the downfall of LRGH was not due to any one factor. One board member suggested that the recommendations of prior management to merge with FRH, construct a new operating room for FRH, acquire private practices, and purchase new equipment were based on a desire to serve the community and did not take into account the negative impact that the decisions would have on LRGH's bottom line. One board member admitted that the board should have recognized that the region's aging demographics could not support the board's vision for LRGH, and the board members should have challenged management's recommendations to take on so much debt. There was also some criticism that management relied too much on debt service to fund its capital projects and not enough on funding from operations and philanthropy. Because of the lengthy tenure and reputation of prior management, some board members did not question the recommendations made by the long-term CEO and CFO. One board member said that the main problem was that "no one conceived that a hospital could go bankrupt" and that the lesson learned from LRGH's experience was that "a hospital can go under."

#### **IV. LRGH'S GOVERNANCE AND MANAGEMENT**

Hospitals are among the most important charities in many communities around New Hampshire. In addition to providing access to life-saving and preventive health care, they play a major role in the social and economic vitality of communities. They do so by addressing the social determinants of health and serving as one of the area's largest employers.

Serving as a member of a hospital board is considered to be prestigious, but because hospitals are so vital to their communities, the work of hospital trustees is exceedingly time-intensive and demanding. The vast majority of hospital trustees are volunteers who generously offer their talents and their time to support the hospital's mission. While we owe a debt of

gratitude to those people who willingly take on these roles, hospital trustees must fully appreciate and effectively exercise the important responsibilities that they have undertaken in their role.

Likewise, hospital executives have very challenging responsibilities. They are charged with ensuring the hospital delivers the best quality patient care, maintaining the overall financial health and stability of the organization, and effectively managing and leading a diverse workforce in a strict regulatory environment. Hospital executives must be able to adapt to the ever-changing health care industry and have the foresight to predict changes that can negatively or positively impact the hospital.

The LRGH experience illustrates the intricacies and challenges faced by hospital trustees and managers and the consequences of the failure to adapt to a changing environment.

A. Board Governance

Hospital trustees, like board members of other charitable nonprofit organizations, owe fiduciary duties to the hospital in light of its purpose. *See* RSA 7:28-e; *Restatement of Charitable Nonprofit Organizations* §2.01 (2021) (hereinafter “*Restatement*”). One of those duties is the fiduciary duty of care or the “duty of attention.” *Restatement* §2.03, comment a. The duty of care means that the trustee must “act in good faith with the care a person of ordinary prudence in a like position would exercise under similar circumstances.” *Restatement* §2.03 (a). The duty is “often characterized as including a duty to be adequately informed when making important decisions for the charity.” *Restatement* §2.03, comment a.

Breaches of the duty of care can fall into three categories: lack of attention in overseeing the affairs of the organization, poor business decision-making, and waste of assets. *See Restatement* §2.03, comment (c). However, decisions of board members generally are not subject

to review for breach of duty if the board members acted in good faith, performed due diligence, were reasonably informed, and reasonably believed at the time that the decision was in the best interests of the organization in light of its purpose and the fact that it has perpetual existence.

*Restatement*, §2.03 (b); §2.03, comment a.

In determining whether a board member acted with the care a prudent person “in a like position would exercise,” the board member’s special skills, background, qualifications, and expertise may be considered. *Restatement* §2.03, comment b (3). Thus, a board member who is an investment advisor must make use of his or her skills and expertise in making decisions pertaining to the charity’s investments. This does not mean, however, that other board members may defer to the investment advisor for those decisions. While the other board members may consider the investment advisor’s views, they must apply their own independent judgment in making decisions. *Id.*

Determining whether a board member acted with the care a prudent person would exercise “in similar circumstances” requires the assessment of a number of factors, including the size, complexity, and purposes of the charity as well as the complexity and importance of the decision. *Restatement* §2.03, comment b (4). That is, “the activities required of a fiduciary to satisfy the standard of care may be more substantial in complex charities than in less complex ones, or more substantial during major events in the life of a charity than at other times.” *Restatement* §2.03, comment b (4).

Hospitals are among the largest, most complex charitable organizations in New Hampshire. As a result, “courts reasonably expect more work and expertise from a fiduciary of an extremely complex charity, such as a hospital, than from a fiduciary of a less complex charity, such as a soup kitchen....” *Restatement*, §2.03, comment b (4).

In this case, we cannot find fault with the LRGH's attention in oversight. The minutes of board meetings reflect good attendance and engagement by the trustees. The board used a committee structure to perform much of its oversight, and the minutes of committee meetings reflect good engagement. The board established an orientation process for new board members and retained well-respected healthcare and leadership consultants to lead annual retreats about, among other things, the role of hospital trustees, changes in the healthcare industry, and strategic planning. The board conducted and reviewed surveys on LRGH's quality metrics, reviewed its financials, and discussed how they could meet the challenges faced by LRGH, improve the quality of the healthcare it offered, and sustain LRGH's mission. It recognized the need to collaborate and enter into partnerships with other healthcare systems and became a member of the Granite Healthcare Network. The LRGH board regularly engaged in a strategic planning process, and in 2015, conducted a review and revisions of its governance policies, which resulted in the reduction of the size of the board to a more manageable 15 members. It also regularly engaged in succession planning for its CEO.

That said, in making major decisions, the board, at least until 2014, deferred too much to the recommendations and conclusions of the long-term executives and failed to challenge the executives. For example, in 2008, LRGH received a management letter from its auditors that reflected a number of significant issues, some of them repeated from the prior year, but there is no indication that the board questioned the CEO or held him (and by extension, the CFO) accountable for the deficiencies. Moreover, the minutes of the February 2009 executive session of the Finance and Investment Committee indicate that the Committee had serious concerns about proceeding with the major capital projects. But less than one month later, the board decided in the presence of the executives to proceed (apparently) with no discussion about the

concerns and risks. In spite of the questions that at least some of the board members had about the project, it does not appear that the board engaged any outside consultants to verify the feasibility of the project.<sup>9</sup> Particularly when LRGH was left with only one option for financing (HUD-insured loan), there should have been more and louder voices casting doubt on the feasibility of the project.

The Board likewise did not challenge the recommendation to enter into the Cerner EHR contract with Speare. While the board knew that LRGH needed to upgrade its medical records system, the minutes of the meetings do not reflect that the board members questioned the cost-sharing arrangement with Speare or asked whether management had explored arrangements with other hospitals, including the members of the Granite Healthcare Network. Rather than exercise their own independent judgment or consult with outside experts, the board relied on the expertise of the CEO and CFO, no doubt guided in part by the executives' long years of service.

Moreover, in light of the fact that the capital improvement plan assumed there would be substantial charitable donations to offset some of the cost, the board should have paid more attention to philanthropy. There was a board philanthropy committee, but the board failed to raise the dollars needed to offset a reasonable portion of the costs incurred from debt financing of the construction projects.

Once the LRGH board realized that the organization was facing a downward financial spiral, it did step up and act properly. With the assistance of KeyBank, the board renegotiated its HUD-insured debt in 2015. With the assistance of Prism Healthcare, beginning in 2016, the board approved difficult cost-cutting measures. With the assistance of Kaufman Hall, the board

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<sup>9</sup> Although LRGH was audited by a CPA firm each year, and an independent auditor was engaged to review the financial feasibility of the project, the role of the auditors essentially was to validate the numbers presented by the CFO and to determine whether the financial projections provided to the auditors by LRGH could be supported. The auditors made it clear that "the achievement of any financial forecast is dependent on future events, the occurrence of which cannot be assured."

embarked in 2018 on a tireless effort to find another hospital or system with which to affiliate. In the end, none of those efforts was sufficient to stave off a bankruptcy filing in 2020.

The road to the 2020 bankruptcy of LRGH was due, in part, to misjudgments made by its trustees between 2007 and 2015, but we cannot conclude that the LRGH board of trustees failed in its fiduciary responsibility to govern the organization. While the trustees should have been more critical of the recommendations of management, the trustees more likely than not acted in good faith, were reasonably informed, exhibited an appropriate level of engagement, and reasonably believed at the time that the decisions made were in the best interests of LRGH. Nonprofits, like businesses, sometimes fail. A dynamic nonprofit sector requires that organizations take risks and seize opportunities. In summary, while the LRGH trustees during the time period between 2007 and 2015 should have made different decisions with respect to the capital expansion project and the Cerner contract, at this point, the trustees' good faith and level of due diligence precludes "further review." *Restatement*, §2.03.

B. Management

As noted above, LRGH experienced decades of concurrent leadership from Mr. Clairmont (over 40 years at LRGH) and Mr. Lipman (over 30 years at LRGH). No doubt the organization enjoyed many tangible and intangible benefits from the experience. The two were leaders in the larger community and promoted LRGH in their many outside roles.

We received several comments that the capital expansion project had become a legacy endeavor for Mr. Clairmont, to assure that LRGH facilities reflected his many contributions over the years to the strength and quality of LRGH. Despite warning signs in the local market and in national health care trends, Mr. Clairmont used his clout with the board of trustees to push through the plan.

Similarly, Mr. Lipman had become prominent locally as an elected official as well as statewide in the New Hampshire Hospital Association.<sup>10</sup> He used his financial expertise to find the HUD-insured financing opportunity, and he presented convincing material to the board's finance committee showing overly optimistic projections as to future revenue and overall margin.

The board of trustees may have shown a more skeptical or realistic eye toward the capital improvements had the recommendations been made by other managers. Perhaps these trustees – many of whom were business leaders in their own right – would have relied more upon their own instincts had they not felt the need to defer to the many decades of experience presented by Messrs. Clairmont and Lipman.

That leads to the question whether LRGH would have been better served had those hospital executives stepped aside sooner. Effective executives recognize the need to make room for new leadership as hospital needs change. While that change can be difficult, it offers a hospital the chance for fresh ideas and new approaches to management.

## V. CONCLUSION

The financial collapse of LRGH was due to a number of factors, and no single person, entity, or cause is to blame. However, the LRGH experience can be instructive for other hospital trustees and executives.

- **The board should continually undergo training and education programs.** Hospitals should establish robust orientation programs for new trustees and provide training for all

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<sup>10</sup> Mr. Lipman has served as a Laconia City Councilor for at least 7 terms. He also served as chair of the New Hampshire Hospital Association (“NHHA”) board of trustees and chair of NHHA’s Advocacy Task Force during the adoption of the New Hampshire Health Protection Plan and the Medicaid Enhancement Tax Agreement. He was awarded New Hampshire Business Review’s 2012 Financial Executive of the Year and was named American Hospital Association’s 2010 Grassroots Champion. In 2015, he was the recipient of the Leslie A. Smith President’s Award for his exceptional contributions to NHHA.

board members regarding their roles and responsibilities as trustees. While it is important for all nonprofit boards to be educated about the trends and challenges that face their organizations, continuing education programs are particularly important for hospital trustees, as the healthcare industry is constantly evolving, and the impact of a failed hospital on the community is so great.

- **Trustees should respectfully question the CEO and hold the CEO accountable.**  
Board meetings should be lively and engaging, and trustees should question the CEO on his or her recommendations. Trustees should not simply defer to management for decision-making, regardless of how long the managers have served and regardless of the managers' reputations. The trustees should establish a vision for the organization and hold the CEO accountable for carrying it out.
- **Trustees should ensure that their decisions are consistent with the hospital's mission and the fact that it has perpetual existence.** While the mission of hospitals is to serve the community, trustees should be careful not to take on or continue activities, programs, projects, or practices that could substantially weaken the hospital's finances. Trustees should understand that hospitals, like businesses, are not immune to failure. Taking chances may be necessary in order to adapt to changes in the industry, but some risks may be too great to undertake.
- **Trustees should consult with outside experts before making major decisions.**  
Trustees may have expertise in particular areas, including investments, finance, law, and healthcare. However, the board should not simply rely on the expertise of other trustees or hospital executives for major decisions that could substantially impact the hospital's ability to carry out its mission. For major decisions, such as a decision to engage in a \$90

million capital project, the board should consult with outside experts to ensure that all members of the board are fully informed and confident that their decisions are in the best interests of the organization.